WITHIN CORPORATE LIMITS

STATE OF MARYLAND—CERTIFICATE OF DEATH

0001

1. PLACE OF DEATH

County Allegheny Registration Dist. No. 4 5

Village or City Cumberland Md. No. 23 Virginia Ave St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME Mrs Arah Easter Alderton If U. S. Veteran, specify WAR .....

(a) Residence: No. 23 Virginia Ave. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Joseph W.

6. DATE OF BIRTH (month, day, and year) June 2 1852

7. AGE Years 87 Months 7 Days 7 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) (State or country) West Virginia

FATHER

13. NAME Hiraim Easter

14. BIRTHPLACE (city or town) (State or country) W. Va.

MOTHER

15. MAIDEN NAME Catherine Huff

16. BIRTHPLACE (city or town) (State or country) W. Va.

17. INFORMANT (Address) Mrs Viola Chartrin

18. BURIAL, CREMATION, OR REMOVAL

Place Capon West Va. Date Jan 16, 1940

19. UNDERTAKER (Address) Virgil L. Lempereur Cumberland Md.

20. FILED Jan. 16, 1940 J. P. Franklin, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Jan. (Month) 14 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 12/15/39, 19..., to 1/14/40, 19...

I last saw her alive on 1/13/40, 19...; death is said to have occurred on the date stated above, at 9 am m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Chronic Myocarditis	

Other Contributory Causes of importance:

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19...

Where did injury occur? ..... (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Richard J. Williams M. D.

(Address) .....

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, **not** the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

RECEIVED FEB 8 1928 BUREAU V. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

0002

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 662 Greene St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town 662 Greene Street Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Cumberland

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Espy Lyon Anderson

3. (b) Social Security Number None

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Henrietta Shoupe

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): June 7 1873

8. AGE: Years 66 | Months 7 | Days 20 | If less than one day ____ hrs. ____ min.

9. Birthplace: Cumberland Md. (Town, county, and state)

10. Usual occupation: Merchant (retired 8 yrs)

11. Industry or business: Grocery.

FATHER
12. Name: Thomas Anderson
13. Birthplace: England

MOTHER
14. Maiden name: Rebecca Johns
15. Birthplace: U. S. A.

16. Informant: Mrs. Henrietta Shoupe Anderson

Address: 662 Greene St. Cumb'd, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 30, 1940 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Md.

19. Jan. 30, 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1940, at 5 25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1st 1938, to Jan 27 1940, and that I last saw him alive on Jan 27 1940.

Immediate cause of death: Chronic myocarditis — DURATION: 5 yrs.

Due to

Due to

Other conditions: Arteriosclerosis — 6 yrs

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE R. H. Trevaskis M.D. M. D. or other

Address Cumberland, Md. Date signed 1/29/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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FEB 6 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-

WITHIN CORPORATE LIMITS

0003

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 133 W. Main

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 133 W. Main (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Catherine Atkinson

3. (b) Social Security Number: none

4. Sex: F

5. Color or race: W

6. (a) Single, married, widowed, or divorced: widowed

B (b) Name of husband or wife: Wm L. Atkinson

6(c) If alive, give age ___ years

7. Birth date of deceased (mo., day, yr.): April 9 — 1865

8. AGE: Years 74 | Months 9 | Days 21 | If less than one day ___ hrs. ___ mtn.

9. Birthplace: Mt Savage Alleg. Md. (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER
12. Name: Michael Lynch
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary Ann Evans
15. Birthplace: England

16. Informant: Mrs Martha Myerson

Address: Cherry Chase, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 1-1940 (month) (day) (year)

Cemetery or ~~crematory~~: St Michaels

Location: Frostburg Md.

18. Funeral director: J J Durst

Address: Frostburg

19. Feb. 1st 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-30-40 1940, at 1 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-1-1933 19__, to 1-30-40 19__, and that I last saw h r alive on 1-29-40 19__.

Immediate cause of death: Malignancy Sigmoid

DURATION: 1½ years

Due to

Due to

Other conditions: Diabetes mellitus, cordis-vascular renal disease

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ___ Date of ___

Where did injury occur? ___ (City or town) ___ (County) ___ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ___ Injured at work?

23. SIGNATURE: W. Alfred Van Ormer M. D. or other

Address: Cumberland, Md. Date signed 1-31-40

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WITHIN CORPORATE LIMITS.

Koon

0004

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 628 Yale St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 628 Yale St.
(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME: Baby Boy Baker

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Infant

6 (b) Name of husband or wife

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Jan. 27, 1940

8. AGE: Years | Months | Days: 1 | If less than one day: 8 hrs. 45 min.

9. Birthplace: Cumberland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Leo Baker
13. Birthplace: Cumberland

MOTHER
14. Maiden name: Wanda Horton
15. Birthplace: Frostburb, Md.

16. Informant: Leo Baker

Address: 628 Yale St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 30, 1940 (month) (day) (year)

Cemetery or crematory: HillCrest Cem.

Location: Cumberland

18. Funeral director: J. C. Wolford

Address: Cumberland, Md.

19. Jan. 30, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 29, 1940, at 2:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 27 1940, to Jan 29 1940, and that I last saw him alive on Jan 27 1940.

Immediate cause of death: Premature Birth 7 Mos

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Thos. A. Koon M. D. or other

Address: Cumberland Md. Date signed: Jan 29-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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FEB 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (180)

CERTIFICATE OF DEATH

0005

Reg. Dist. No. 1

1. PLACE OF DEATH:
County Allegany
City or town Oldtown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 1 yr 6 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegany
City or town Oldtown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Charles Roy Bartlett

3. (b) Social Security Number

4. Sex M
5. Color or race W
6. (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 25, 1930
8. AGE: Years 9 Months 4 Days 15 If less than one day hrs. min.
9. Birthplace Lonaconing Md (Town, county, and state)
10. Usual occupation ✓
11. Industry or business ✓
FATHER 12. Name Charles Bartlett
13. Birthplace Washington, D.C.
MOTHER 14. Maiden name Frances M. Crow
15. Birthplace Frostburg, Md
16. Informant Chester C Benson
Address Oldtown Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 12, 1940 (month) (day) (year)
Cemetery or crematory Spring Gap
Location Oldtown Road
18. Funeral director Jacob Safer
Address Cumberland
19. Jan 11 1940 (Date rec'd by registrar) Mrs. L. A. Shamholtz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10 1940, at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19,
and that I last saw h alive on 19.
Immediate cause of death Burning.
Minute fragments (charred) of body remains.
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Accident Date of 1-10-1940
Where did injury occur? Oldtown, Allegany, Maryland. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) home
Means of injury burning Injured at work? no

23. SIGNATURE Pierce H. Borson, M.D. M. D. or other
Address Cumberland, Maryland Date signed 1/10/40

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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FEB 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 9

CERTIFICATE OF DEATH

0006

1. PLACE OF DEATH:

(a) County: Allegany

(b) City or town: Frostburg (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital or institution: 140 Bowery St.

(d) Length of stay in hospital or inst. (yrs., mos., or days):

(e) Length of stay in this community (yrs., mos., or days): life

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State: Md. (b) County: Allegany

(c) City or town: Frostburg (If outside city or town limits, write RURAL and give town)

(d) Street No.: 140 Bowery St. (If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME**: Wm. Victor Beeman

3 (b) If veteran, name war:

3 (c) Social Security No.:

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife:

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): October 7, 1939

8. AGE: Years —; Months 2; Days 27; If less than one day ____ hr. ____ min.

9. Birthplace: Frostburg, Allegany, Md (Town, county, and state)

10. Usual occupation:

11. Industry or business: —

FATHER 12. Name: Noah J. Beeman, Jr.

FATHER 13. Birthplace: Frostburg, Md.

MOTHER 14. Maiden Name: Emma G. Meagher

MOTHER 15. Birthplace: Frostburg, Md.

16 (a) Informant: Noah J. Beeman, Jr.

(b) Address: Frostburg, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-5-40 (month) (day) (year)

(c) Cemetery or crematory: Allegany

Location: Frostburg Md.

18 (a) Funeral director: Jacob Saber

(b) Address: Frostburg, Md.

19 (a) 1-5 (Date rec'd by registrar) 1940 (b) Mark L. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death Jan. 3 1940, at 1 00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1940, to Jan. 3 1940, and that I last saw him alive on Jan. 2 1940.

Immediate cause of death	Duration
Convulsions	1 hr.
Due to La Grippe	3 days.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence:

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury:

23. Signature: W. E. Gattens M. D. (M. D. or other)

Address: Frostburg, Md Date signed 1/4/40.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

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FEB 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (107)

Reg. Dist. No. 9

0007

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Frostburg
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Miner's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 12 hrs

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County Garrett
(c) City or town Jennings
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Lola Elaine Bittinger

3 (b) If veteran, name war

3 (c) Social Security No. none

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. child

6 (b) Name of husband or wife —

6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar, 18 - 1937

8. AGE: Years 2 Months 9 mos Days 26 If less than one day ___ hr. ___ min.

9. Birthplace Jennings Md
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name Ervin R. Bittinger
13. Birthplace Jennings Md.

MOTHER
14. Maiden Name Sadie Alberta Bittner
15. Birthplace Jennings Md.

16 (a) Informant Ervin R. Bittinger
(b) Address Jennings, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 28-1940 (month) (day) (year)
(c) Cemetery or crematory Hoover Cem.
Location near Jennings, Md

18 (a) Funeral director Ervin R. Bittinger
(b) Address Jennings, Md

19 (a) Jan. 26-1940 (Date rec'd by registrar) (b) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death Jan. 26 1940, at 3:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 25 1940, to Jan. 26 1940; and that I last saw him alive on Jan. 25 1940.

Immediate cause of death Bronchopneumonia — Duration 4 days.
There was no associated disease; except a bad cold, for ten days or two weeks. C.W.G.
Due to
Due to
Other conditions Very unsatisfactory history.
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. E. Gattens M.D.
M. D. or other
Address Frostburg, Md. Date signed 1/26/40.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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FEB 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-8)

CERTIFICATE OF DEATH

0008

Reg. Dist. No. 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Mt. Savage Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 40 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegany
City or town Mt. Savage Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Wm. P. Bridges

3. (b) Social Security Number Soc. Sec. 063-12-2218

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870 Mar 30

8. AGE:

Years	Months	Days	If less than one day
69	9	26	hrs. min.

9. Birthplace Cumberland Valley Penn
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business Coal Mines
FATHER 12. Name Benton Bridges
13. Birthplace Cumberland Valley Penn
MOTHER 14. Maiden name Anna Miller
15. Birthplace Cumberland Valley Penn
16. Informant J. Ralph McCusker
Address Mt Savage, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 27, 1940 (month) (day) (year)
Cemetery or crematory St. Patricks Cemetery
Location Mt. Savage Md.
18. Funeral director Jacob Hafer
Address Cumberland Md.
19. Jan 26 1940 (Date rec'd by registrar) H. J. Boblitz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 1940, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1940, to Jan 29 1940, and that I last saw him alive on Jan 26 1940.

Immediate cause of death Chronic nephritis — DURATION ?
Due to — DURATION
Due to — DURATION
Other conditions — DURATION
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wm McLane Jr M.D. M. D. or other
Address Frostburg Md Date signed Jan 26 1940

RECEIVED
FEB 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (830)

CERTIFICATE OF DEATH

0009

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany County
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days): 4 days
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett
City or town: Oakland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Dr. Irvin Broadwater

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: June Bowden Broadwater
6(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): August 8, 1883

8. AGE: Years	Months	Days	If less than one day
56	4	24	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: Physician
11. Industry or business: Own practice
FATHER 12. Name: Gilead Broadwater
13. Birthplace: Maryland
MOTHER 14. Maiden name: Ada Maust
15. Birthplace: Pennsylvania
16. Informant: Memorial Hospital
Address: Cumberland, Maryland
Removal and Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 4, 1940 (month) (day) (year)
Cemetery or crematory: Oakland
Location: Oakland, Md.
18. Funeral director: Emory D. Boldeea,
Address: Oakland, Md.
19. Jan. 3, 1940 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

DR. W.F.WILLIAMS

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 2, 1940, at 9:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-2-39 1939, to 1-2-40 1940, and that I last saw h[illegible] alive on Jan. 2 1940.

Immediate cause of death: Cerebral Hemorrhage — DURATION: 2 days
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other
Address: Cumberland Date signed: 1-3-40

RECEIVED
FEB 6 1940
BUREAU V. S.

0010

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95C)

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 64 yrs - 11 mos. 8 das.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing Ward No. —
(If outside city or town limits, write RURAL NEAR and give town)

Street No. —
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME: James Clarkson

Ross. 03-05-76
355-01-0312

3. (b) Social Security Number: None

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Feb 7 1875

8. AGE: Years: 64 Months: 11 Days: 18 If less than one day ___ hrs. ___ min.

9. Birthplace: Lonaconing Allegany Co., Md
(Town, county, and state)

10. Usual occupation: Miner

11. Industry or business: Coal Mine

FATHER
12. Name: Thomas Clarkson
13. Birthplace: Scotland

MOTHER
14. Maiden name: Annie Lyle
15. Birthplace: Scotland

16. Informant: Mrs Dent Richter
Address: Lonaconing Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 28, 1940 (month) (day) (year)

Cemetery or crematory: Old Coney Cemetery

Location: Lonaconing Md.

18. Funeral director: M. Eichhorn
Address: Lonaconing Md.

19. Jan 27 1940 (Date rec'd by registrar) E. Ora Taylor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 25 1940, at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1937, to Jan 1940, and that I last saw him alive on Jan 20 1940.

Immediate cause of death: Cardiac asthma
Miner's asthma

DURATION: 10 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Joseph Friedman M. D. or other

Address: Westernport Md. Date signed: Jan 26, 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

CERTIFICATE OF DEATH

0011

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 221 Fayette St.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 221 Fayette St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: William H. Coleman

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 2, 1869.

8. AGE: Years	Months	Days	If less than one day
70	10	24	hrs. min.

9. Birthplace: Cumberland Md. (Town, county, and state)

10. Usual occupation: Retired Salesman

11. Industry or business:

FATHER — 12. Name: Henry A. Coleman

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Sarah Busey

15. Birthplace: Virginia

16. Informant: Sarah E. Coleman

Address: 221 Fayette St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 26, 1940 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland

18. Funeral director: J. C. Wolford

Address: Cumberland, Md.

19. Jan. 25, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 23, 1940, at 5:30

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 10 1940, to Jan. 22 1940, and that I last saw him alive on Jan. 22 1940.

	CURATION
Immediate cause of death: Chronic Myocarditis	4-10-36
Due to: Chronic Endocarditis	4-10-36
Due to: Arteriosclerosis	1930
Due to: Coronary Thrombosis	1936
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: None

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. R. Larson M.D. M. D. or other

Address: 126 Union St. Cumb. Md. Date signed: 1/24/40

RECEIVED
FEB 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

0012

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Williams Road R.F.D.#2
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mr. Albert Davis

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 1, 1876

8. AGE: Years	Months	Days	If less than one day
63	10	22	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Farming
11. Industry or business

FATHER
12. Name: Lewis Davis
13. Birthplace: Maryland

MOTHER
14. Maiden name: Louisa Gleichman
15. Birthplace: Maryland

16. Informant: Charles L. Davis
Address: R.D.#2. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 24, 1940 (month) (day) (year)
Cemetery or crematory: Mt. Herman Cem.
Location: Williams Road near Cumberland
18. Funeral director: J. C. Wolford
Address: Cumberland, Md.

19. Jan. 24, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 23 19 40, at 4:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 19 40, to Jan. 23 19 40 and that I last saw h[im] alive on Jan 23 19 40.

	DURATION
Immediate cause of death: Diabetes Mellitus	?
Due to	
Due to	
Other conditions: Left Hemiplegia	2
	+ wks

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: A. Boyce Hodges, M.D.
M. D. or other
Address: Cumberland, Md. Date signed: 1/24/40

RECEIVED
FEB 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-C)

CERTIFICATE OF DEATH

0013

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 225 Harrison St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 50 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 225 Harrison St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Odell Deal

3. (b) Social Security Number none retired 1939

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

B (b) Name of husband or wife Ingrette E. Feichtner

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 12 1856

8. AGE: Years	Months	Days	If less than one day
83	5	5	hrs. min.

9. Birthplace Deal, Pa. (Town, county, and state)
10. Usual occupation Merchant
11. Industry or business Flour Mill
FATHER 12. Name Edwin Deal
13. Birthplace Pa
MOTHER 14. Maiden name Nancy Lipley
15. Birthplace Pa
16. Informant Mrs Ralph D Brodrup
Address Cumberland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-19-40 (month) (day) (year)
Cemetery or crematory Rose Hill Cem.
Location Cumberland
18. Funeral director Louis Stein Sons
Address Cumberland
19. Jan. 19, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 28 1939 to Jan. 17 1940, and that I last saw h— alive on Jan. 16 1940

Immediate cause of death	DURATION
Chronic Endocarditis	1937.
+ Chronic Nephritis.	1934
Due to Chronic Bronchitis	1938
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. P. Franklin M.D. M. D. or other
Address Cumberland Md Date signed

RECEIVED
FEB 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3)

CERTIFICATE OF DEATH

0014
4

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegeny
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegeny Hospital
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Penna. County
City or town Warford & burg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Still Born Baby Girl Deneen

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Baby

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 10, 1940

8. AGE: Years Months Days If less than one day hrs. min.
Stillborn

9. Birthplace Cumberland, Md. (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Lester Deneen
13. Birthplace Warfordsburg, Penna

MOTHER 14. Maiden name Goldie Virginia Stitzpoe
15. Birthplace Virginia

16. Informant Allegany Hospital
Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 11, 1940 (month) (day) (year)
Cemetery or crematory ~~Pine~~ Zion Lutheran Cem.
Location Red Vine Run

18. Funeral director Jacob Hafer
Address 230 Baltic Ave, Cumberland, Md.

19. Jan. 11 19 40 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10 1940, at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 10 1940 to Jan 10 1940, and that I last saw her alive on Jan 10 1940.

Immediate cause of death	DURATION
Intrauterine asphyxia	
Due to	
Due to	
Other conditions Prematurity (5 mo gestation)	

(Include pregnancy within 3 months of death)

Major findings:
Ot operations
Ot autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Ogden T. Jones M. D.
M. D. or other
Address 40 N. Liberty St. Date signed 1-10-40

RECEIVED
FEB 6 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94th)

CERTIFICATE OF DEATH

0015

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: East Main
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 52 yrs 5 mos 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: East Main
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Francis Dolan

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Christina Dorothy Dolan
6(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): Aug. 26, 1887

8. AGE:

Years	Months	Days	If less than one day
52	5	4	hrs. min.

9. Birthplace: Lonaconing, Allegany, Maryland (Town, county, and state)
10. Usual occupation: Beer Distributor - Retired
11. Industry or business: Brewing Co.

FATHER
12. Name: Dennis Dolan
13. Birthplace: Ireland

MOTHER
14. Maiden name: Anne Murray
15. Birthplace: Ireland

16. Informant: Patrick Dolan
Address: Lonaconing Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 2, 1940 (month) (day) (year)
Cemetery or crematory: St Mary's Cemetery
Location: Lonaconing, Md.

18. Funeral director: E. Eichhorn
Address: Lonaconing, Md.

19. Feb. 1 1940 E. Don Taylor
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 30 1940, at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 18 1938, to June 30 1940, and that I last saw h- alive on June 5th 1940.

	DURATION
Immediate cause of death: Uraemia Poisons	Several years
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Henry M. Hodgson M. D. or other
Address: Lonaconing Md. Date signed: Jan 31 40

RECEIVED
FEB 6 1940
BUREAU V. S

WITHIN CORPORATE LIMITS

STATE OF MARYLAND—CERTIFICATE OF DEATH

0016

1. PLACE OF DEATH

County Allegany Registration Dist. No. 4

Village or City Cumberland No. 110 Humbird St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred Cpe yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Stillborn Dyer If U. S. Veteran, specify WAR

(a) Residence: No. 110 Humbird St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female

4. COLOR OR RACE white

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Stillborn

6. DATE OF BIRTH (month, day, and year) Jan 8 1940

7. AGE Years Months Deys If LESS than 1 day, hrs. or min. Stillborn

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Stillborn

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month end year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Cumberland Md (State or country)

FATHER

13. NAME Herbert B. Dyer

14. BIRTHPLACE (city or town) Gayloyd Va. (State or country)

MOTHER

15. MAIDEN NAME Sarah K. Brewer

16. BIRTHPLACE (city or town) Ridgely W Va (State or country)

17. INFORMANT Herbert B Dyer (Address) 110 Humbird

18. BURIAL, CREMATION, OR REMOVAL Place Hillcrest Cem Date Jan 8, 1940

19. UNDERTAKER Louis Stein Inc (Address) Cumberland Md

20. FILED Jan. 8, 1940 J. P. Franklin, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH January 8, 1940 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan 8, 1940, to Jan 8, 1940

I last saw her alive on Stillborn Jan 8, 1940; death is said to have occurred on the date stated above, at 4 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importence were as follows:

Stillborn

Date of onset

Other Contributory Causes of Importance:

Name of operation Date of

What test confirmed diagnosis? Clinical Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) W. S. Brown M. D.

(Address) 133 Va

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at **school** or at **home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The **principal cause of death** and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other **contributory causes of importance:**	
Gallstones	*May 1, 1923*

Example II

The **principal cause of death** and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other **contributory causes of importance:**	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-2)

0017

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 110 Columbia St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Virginia O. Edenhart

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Clarence E Edenhart

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): April 4 1900

8. AGE: Years 39 Months 8 Days 21 If less than one day ____ hrs. ____ min.

9. Birthplace: Whitman West Va
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: John H Clayton
13. Birthplace: West Va.

MOTHER
14. Maiden name: Susan C Agery
15. Birthplace: West Va

16. Informant: Clarence Edenhart
Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 27, 40 (month) (day) (year)

Cemetery or crematory: Hillcrest

Location: Cumberland Md

18. Funeral director: Louis Stein Inc
Address: Cumberland Md

19. Jan. 25, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 24 1940, at 8 10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1939, to Jan 24 1940, and that I last saw h[illegible] alive on Jan 24 1940.

Immediate cause of death: Congenital Pulmonary Stenosis

Due to: Pulmonary Hemorrhage. No Tuberculosis.

Due to: Congestive Heart Failure

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: R. C. Bowen M.D. M. D. or other

Address: Cumberland Md Date signed: 1-24-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Bowen.

RECEIVED
FEB 8 1940
BUREAU V. S.

Outside of City Limits

CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-8)

0018

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Rural near
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 4 miles east on Uhl Highway residence of Thomas H. Smith

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 3 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland, Rural near Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Uhl Highway Rt 4 - Bx 70
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: William B. Edmonson (alias-Henry Martin)

3. (b) Social Security Number: 220-10-9260

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

B (b) Name of husband or wife: Frances Cecelia Smith

6(c) If alive, give age: 25 years

7. Birth date of deceased (mo., day, yr.): October 9, 1910

8. AGE: Years: 29 Months: 2 Days: 30 If less than one day: hrs. min.

9. Birthplace: Marrietta, Ohio
(Town, county, and state)

10. Usual occupation: Textile worker

11. Industry or business: Celanese

FATHER
12. Name: ??? Edmonson
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: ??

16. Informant: Mrs. Franes Smith Edmonson
Address: Uhl Highway, near Cumberland, Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: January 10, 1940
(month) (day) (year)

Cemetery or crematory: Davis Memorial Cemetery

Location: Uhl Highway near Cumberland, Md.

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Maryland

19. Jan. 9, 1940 J. P. Franklin, M. D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: ~~Jan 8~~ Jan. 7 1940, at 10:40 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 7 1940, to Jan 8 1940, and that I last saw him alive on Jan 7 1940.

Immediate cause of death: Pulmonary Intussulosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy: no

DURATION: about 1 year

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: 133 Valley Date signed: 1/8/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92a)

CERTIFICATE OF DEATH

0019

Reg. Dist. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: Miller Mine - Near Frostburg (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 50 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Miller Mine Near Frostburg (If outside city or town limits, write RURAL NEAR and give town)

Street No.: — Route R.D.I (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Mary Elizabeth Wagus Emerick

3. (b) Social Security Number: —

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James J. Emerick

6(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): May 4, 1866

8. AGE: Years: 73 Months: 8 Days: 3 If less than one day: ___ hrs. ___ min.

9. Birthplace: Vale Summit, Allegany Co., Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER
12. Name: Henry Wagus
13. Birthplace: Wellersburg, Pa

MOTHER
14. Maiden name: Hannah Albright
15. Birthplace: Wellersburg, Pa.

16. Informant: Mr. James J. Albright

Address: Frostburg, Md. R.D.I

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 9th 1940 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: M. Eichhorn

Address: Ronaconing, Md.

19. Jan. 9 1940 (Date rec'd by registrar) Dr. E. Don Taylor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 7 1940, at 9 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1939, to Jan 5 1940, and that I last saw her alive on Jan 5 1940.

Immediate cause of death: Coronary Occlusion

Due to: Rheumatic Endocarditis.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. M. Shelton Jr. M.D. (M. D. or other)

Address: Midland, Md. Date signed: Jan 8, 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 6 1940
BUREAU V. S.

Outside of City Limits

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73a)

0020

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town R.D.#1. Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Grove

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. R.D.#1., Allegany Grove
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Gertrude Everline

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Fem.	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1885

8. AGE: Years	Months	Days	If less than one day
54	7	18	hrs. min.

9. Birthplace Wellersburg, Penna.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name Daniel Everline
13. Birthplace Germany

MOTHER
14. Maiden name Dora Milford
15. Birthplace Germany

16. Informant Mr. Henry Everline

Address R.D.#1. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 20, 1940 (month) (day) (year)

Cemetery or crematory Wellersburg Cem.

Location Wellersburg, Penna.

18. Funeral director J. C. Wolford

Address Cumberland, Md.

19. Jan. 19, 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18, 1940, at 2:30 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 12 1940, to Jan 18 1940, and that I last saw h[illegible] alive on Jan 15 1940.

Immediate cause of death Anaemia (Pernicious) — DURATION about 10 yr

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) no

Means of injury no Injured at work?

23. SIGNATURE [illegible] M. D. or other

Address 133 Va [illegible] Date signed 1/19/40

RECEIVED
FEB 6 1940
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

WITHIN CORPORATE LIMITS

CERTIFICATE OF DEATH

0021

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 87 Armstrong

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 87 Armstrong
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: No

3. (a) FULL NAME: John Festerman

3. (b) Social Security Number: No record A-O-D

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Annie Festerman

6(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Sept 6 — 1869

8. AGE:

Years	Months	Days	If less than one day
70	3	28	____ hrs. ____ min.

9. Birthplace: Mt. Savage Md.
(Town, county, and state)

10. Usual occupation: Retired Coal Miner

11. Industry or business: Coal Mines

FATHER 12. Name: Charles Festerman

13. Birthplace: Germany

MOTHER 14. Maiden name: Elizabeth Eisle

15. Birthplace: Germany

16. Informant: Wm Festerman

Address: Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 6 — 1940 (month) (day) (year)

Cemetery or ~~crematory~~: allegany

Location: Frostburg md.

18. Funeral director: J. J. Durst

Address: Frostburg

19. 1 — 6 — 19 40 (Date rec'd by registrar) mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 3 1939, at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 2 1938, to Jan 3 1939, and that I last saw him alive on Dec 1 1938

Immediate cause of death	DURATION
Chronic Myocarditis	2
Due to Arteriosclerosis	7
Due to Senility	7
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. M. Lane Jr. M. D. or other

Address: Frostburg Md Date signed: Jan 5 39

RECEIVED
FEB 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

CERTIFICATE OF DEATH

0022

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address (hospital) or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days) 7 days.
Stay in this community (yrs., or mos., or days) 6 years.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 805 Washington St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Lawrence Francis Flynn

3. (b) Social Security Number 214-05-7408 Ross

4. Sex Male

5. Color or race White

6.(a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rose Spitler

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) August 1898

8. AGE: Years 41 | Months 4 | Days | If less than one day ____ hrs. ____ min.

9. Birthplace New York City
(town, county, and state)

10. Usual occupation manager

11. Industry or business Retail store

FATHER
12. Name Matthew Flynn
13. Birthplace Ireland

MOTHER
14. Maiden name Anna Rice
15. Birthplace Ireland

16. Informant Mrs Rose Flynn
Address 805 Washington St Cumb'd Md

17. Removal (Burial, cremation, or removal) Date thereof 1-15-40 (month) (day) (year)
Cemetery or crematory Holy Cross Cem
Location Akron, Ohio

16. Funeral director Louis Stein Inc.
Address Cumberland Md.

Jan 15 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-12 1940, at 11:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 9 1940, to Jan 12 1940, and that I last saw h/ alive on Jan 12 1940.

	DURATION
Immediate cause of death Cardiac paralysis	4 days
induced by alcoholism	
delirium	
Due to Chronic Endocarditis	over 1 yr
Due to To my knowledge	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. V. Deming M.D.
M. D. or other
Address 67 N. Center St Date signed 1-13/40

RECEIVED
FEB 6 1969
BUREAU V. S.

WITHIN CORPORATE LIMITS. (3474)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-C)

CERTIFICATE OF DEATH

0023

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany.
City or town Cumberland.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital or institution: 545 N. Mechanic St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 30 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany.
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 545 N. Mechanic St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary B. Folk.

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Jesse Folk.
B(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3. 1867

8. AGE:

Years	Months	Days	If less than one day
77	5	27	hrs. min.

9. Birthplace Maryland.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Joseph Gallagher 13. Birthplace Ind.
MOTHER 14. Maiden name Sarah A. McKenzie 15. Birthplace Ind.
16. Informant Mrs Mamie B. Boyden.
Address Cumberland.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 3, 40 (month) (day) (year)
Cemetery or crematory Rose Hill Cem.
Location Cumberland
18. Funeral director Louis Stein Inc.
Address Cumberland
19. Jan 3 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 1940, at 6:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 10 1939, to Jan 1 1940, and that I last saw h[illegible] alive on Dec 30 1939.

	DURATION
Immediate cause of death (a) Cerebral Hemorrhage	3 yrs
Due to (b) Arteriosclerosis	3 yrs
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Elliott P. Franklin M. D. or other
Address Cumberland Md. Date signed

RECEIVED
FEB 8 1940
BUREAU V. S.

0024

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany

City or town Westernport (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 430 Vine

Stay in hospital or inst. (yrs., or mos., or days) 3 Mo 8

Stay in this community (yrs., or mos., or days) ✓

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Allegany

City or town Westernport Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 430 Vine (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Barbara Lou Gentile Gentile

3. (b) Social Security Number None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 14, 1939

8. AGE: Years | Months 3 | Days 8 | If less than one day ___ hrs. ___ min.

9. Birthplace Westernport, Allegany - Md (Town, county, and state)

10. Usual occupation —

11. Industry or business

FATHER: 12. Name John Gentile; 13. Birthplace Piedmont, W. Va

MOTHER: 14. Maiden name Louise Hines; 15. Birthplace Westernport, Md

16. Informant John Gentile

Address Westernport, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 24, 1940 (month) (day) (year)

Cemetery or crematory Philos

Location Westernport, Md.

18. Funeral director D. S. Boal

Address Westernport, Md.

19. Jan. 24 1940 (Date rec'd by registrar) A J Gaynbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22, 1940, at 9:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 22 1940, to Jan 22 1940, and that I last saw him alive on Jan 22 1940.

Immediate cause of death: Bronchio pneumonia

Due to Cold

Due to

Other conditions Bilateral otitis media (Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: P

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE [signature] M.D. or other

Address Westernport Date signed Wed 1/23/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1940
BUREAU V. S.

WITHIN CORPORATE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

CERTIFICATE OF DEATH

0025

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND MARYLAND (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) 11 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND MARYLAND Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 514 MD. AVE. CITY (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME DANIEL H. GRAPES

3. (b) Social Security Number 705-09-6688

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife Lillian M Moser

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May Oct. 6, 1880

8. AGE: Years 58 59 | Months 3 | Days 18 | If less than one day ____ hrs. ____ min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation CAR INSPECTOR

11. Industry or business Railroad

FATHER 12. Name ISAAC GRAPES

13. Birthplace WEST VIRGINIA

MOTHER 14. Maiden name ELIZABETH EDWARDS

15. Birthplace WEST VIRGINIA

16. Informant Mrs Lillian Grapes

Address Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 28 40 (month) (day) (year)

Cemetery or crematory Dunkard Cemetery

Location Pleasant Dale, W. Va

18. Funeral director Louis Steinman

Address Cumberland Md

19. Jan. 25 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

R. RICHARD WILLIAMS

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 24 1940, at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/3/40 19__, to 1/24/40 19__, and that I last saw h alive on 1/24/40 19__.

Immediate cause of death	DURATION
Chronic Myocarditis	
Myocardial Failure	
Due to	
Chronic Alcoholism	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Richard H Williams M.D. M. D. or other

Address 34 Va Ave. Date signed 1/24/40

Cumberland Md

Authorization to change date of birth see letter filed under Williams. 4/6/40

RECEIVED
FEB 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (926)

CERTIFICATE OF DEATH

0026

Reg. Dist. No. 6

1. PLACE OF DEATH:
County All Alleganey
City or town Luke
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital or institution 415 Pratt
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 30 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Alleganey
City or town Luke Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 415. Pratt
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John Thomas Grove

3. (b) Social Security Number 212-12-8123

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Sarah Elizabeth Grove
6(c) If alive, give age 65 years
7. Birth date of deceased (mo., day, yr.) March 23, 1864
8. AGE: Years 75 Months 9 Days 9 If less than one day ___ hrs. ___ min.
9. Birthplace near) Westernport, Garrett, Md
(Town, county, and state)
10. Usual occupation Switch Board Operator
11. Industry or business Paper- Mill
FATHER 12. Name William Grove
13. Birthplace Barton, Md.
MOTHER 14. Maiden name Aseneth Dawson
15. Birthplace Dawson, Md.
16. Informant Troxell Grove
Address Luke, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan, 5, 1940 (month) (day) (year)
Cemetery or crematory Philos
Location Westernport, Md
18. Funeral director D.S.Boal
Address Westernport, Md.
19. Jan 5 1940 (Date rec'd by registrar) A J Gaynbaker MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2 1940, at 3.45p
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 29 1939, to Jan 2 1940, and that I last saw him alive on Jan 2 1940.
Immediate cause of death Myocarditis Chronic — DURATION 5 yrs.
Mitral regurgitation — 5 "
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert W. Bess M.D.
M. D. or other
Address Piedmont Wva. Date signed 1-5-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

0027

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 105 Greene Street
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 105 Greene Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Lucy Hamilton

3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Maxwell Hamilton
6 (c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): May 18, 1854
8. AGE: Years 84 Months 6 Days 20 If less than one day ____ hrs. ____ min.
9. Birthplace: Eckart, Allegany, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At home
FATHER
12. Name: Patrick Roney
13. Birthplace: Ireland
MOTHER
14. Maiden name: Mary Hynes
15. Birthplace: Ireland
16. Informant: Mrs. Estella Farrell
Address: 105 Greene St., Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof January 9, 1940 (month) (day) (year)
Cemetery or crematory: St. Patrick Cemetery
Location: Cumberland, Maryland
18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland
19. Jan. 8, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar
Dr. Enfield

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 8 1940, at 9:30 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1940, to Jan 8 1940, and that I last saw her alive on Jan 7 1940.
Immediate cause of death: Acute Dilatation of heart
Due to: Chronic Myocarditis
Due to:
Other conditions: Decomp fell fracturing ribs & Gland
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of Jan 1-40
Where did injury occur? Cumberland (City or town) Allegany (County) Md (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: Missed chair sitting down Injured at work? no

23. SIGNATURE: J. E. Enfield M. D. or other
Address: Cumberland Date signed 1/8/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0028

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1315 River Avenue
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Ray Hampton

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 6, 1939

8. AGE: Years	Months	Days	If less than one day
0	5	12	hrs. min.

9. Birthplace: South Carolina
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Virskel Hampton
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Earmae Melton
15. Birthplace: North Carolina

16. Informant: Virskel Hampton
Address: 1315 River Ave, Cumb'd. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 22 1940 (month) (day) (year)
Cemetery or crematory: Frankfort Cemetery
Location: Frankfort, W. Va.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.

19. Jan. 22, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January - 19 - 1940 at 10:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January - 18 1940, to Jan - 19 1940, and that I last saw him alive on Jan - 19 - 1940.

	DURATION
Immediate cause of death: Bronchopneumonia	1 wk.
The bronchopneumonia was primary	
Due to: There was no associated disease. C.W.F.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. W. Eleason M.D. M. D. or other
Address: 126 Union St Cumberland Md. Date signed: 1/22/40

RECEIVED
FEB 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

0029

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or Institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1 hour

Stay in this community (yrs., or mos., or days): 35 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 436 Race St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: Lawrence Hansrote

3. (b) Social Security Number: 214-07-1160

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

B (b) Name of husband or wife: Cleda S. Hansrote

B(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): April 1, 1884

8. AGE:

Years	Months	Days	If less than one day
55	9	5	____ hrs. ____ min.

9. Birthplace: Martinsburg, W. Va. (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Retail Dry Goods Notions

FATHER

12. Name: Adam Hansrote

13. Birthplace: Hansrote, W. Va.

MOTHER

14. Maiden name: Lillian Johnson

15. Birthplace: Martinsburg, W. Va.

16. Informant: Cleda S. Hansrote

Address: 436 Race St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-9-40 (month) (day) (year)

Cemetery or crematory: Union Cemetery

Location: Meyersdale, Penna.

18. Funeral director: Jacob Hafer

Address: Cumberland, Md.

19. Jan. 8, 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

Dr. Burrett

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 6, 1940, at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 6, 1940, to Jan. 6, 1940, and that I last saw him alive on Jan. 6, 1940.

	DURATION
Immediate cause of death: Coronary Thrombosis	15 min.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Clay R. Burrett M. D. or other

Address: Cumberland, Md. Date signed: Jan. 8, 1940.

RECEIVED
FEB 6 1900
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0030 9

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 27 Charles St.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 27 Charles St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Gwendolyn Dudley Harris

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

6 (b) Name of husband or wife: David L. Harris

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 11 — 1858

8. AGE: Years	Months	Days	If less than one day
81	5	22	hrs. min.

9. Birthplace: Wales
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER — 12. Name: Thomas Jeffreys

FATHER — 13. Birthplace: Wales

MOTHER — 14. Maiden name: unknown ?

MOTHER — 15. Birthplace:

16. Informant: Mrs. Charles Cole

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 4-1940 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg, Md.

18. Funeral director: J. J. Dent

Address: Frostburg

19. Jan. 4 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 2 1940, at 4 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 27 1939, to Jan. 2 1940, and that I last saw her alive on Jan 2 1940.

Immediate cause of death	DURATION
Chronic myocarditis	
Due to arteriosclerosis	
senility	
Due to	
Other conditions	
(Include pregnancy within 3 months of death)	

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: X Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. C. Diehl M.D.
M. D. or other

Address: Frostburg, Md. Date signed: 1/3/40

RECEIVED
JAN 12 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 85

WITHIN CORPORATE LIMITS

CERTIFICATE OF DEATH

0031

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
35 W. Loo St

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 65

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 35 W Loo St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Catherine Hartig

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

6 (b) Name of husband or wife Martin Hartig

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28, 1853

8. AGE:

Years	Months	Days	If less than one day
86	9	13	hrs. min.

9. Birthplace Frostburg Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Henry Dilfer
13. Birthplace Germany

MOTHER
14. Maiden name Catherine Frank
15. Birthplace Germany

16. Informant Emma Hartig

Address 35 W. Loo St. Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 13, 1940 (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18. Funeral director Jack Hafer

Address 69 E. Main St.

19. Jan. 13 1940 Mrs. A. R. Walker
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11 1940, at 8 00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 6 1940 to Jan 11 1940, and that I last saw her alive on Jan 11 1940.

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 Day
Rt Hemiplegia	—
Due to arteriosclerosis	—
Due to senility	—
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations no

Of autopsy no

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm Lane MD M. D. or other

Address Frostburg Md Date signed Jan 12 1940

Dr. McLean –

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

0032

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (142 B)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 1 hr. 40 min.

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 212 Pine Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs. Edythe Hanselman

3. (b) Social Security Number 220-03-7581

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Victor Hanselman

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Feb. 11, 1910

8. AGE: Years 29 | Months 10 | Days 24 | If less than one day ____ hrs. ____ min.

9. Birthplace: Hyndman, PA.
(Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business

FATHER
12. Name: John Troutman
13. Birthplace: Hyndman, Pa.

MOTHER
14. Maiden name: Mary Smith
15. Birthplace: Hyndman, Pa.

16. Informant: MR. Glen Troutman

Address: Hyndman, PA.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/8/40 (month) (day) (year)

Cemetery or crematory: Comps.

Location: Somerset County, PA.

18. Funeral director: Harvey H. Zeigler

Address: Hyndman, Pa.

19. Jan 6, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5, 1940, at 11:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 5 1940, to January 5 1940, and that I last saw her alive on January 5, 1940.

Immediate cause of death: Ruptured Extrapic Pregnancy

DURATION: 12 hours

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: B. M. Schindler M.D. M. D. or other

Address: 41 Greene St. Date signed: Jan 6/1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 6 1950
BUREAU Y. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (44?)

CERTIFICATE OF DEATH

0033

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hosp

Stay in hospital or inst. (yrs., or mos., or days): 1 day

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 768 Fayette St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: George Paul Kilton

3. (b) Social Security Number: 214-05-6265

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marion Chase

6(c) If alive, give age: 31 years

7. Birth date of deceased (mo., day, yr.): July 6, 1903

8. AGE: Years: 36 Months: 6 Days: 14 If less than one day: hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business: Glanese Corp.

FATHER 12. Name: George Kilton

FATHER 13. Birthplace: Penna

MOTHER 14. Maiden name: Cora Mouse

MOTHER 15. Birthplace: Penna

16. Informant: Memorial Hosp.

Address: Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 23-40 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland, Md.

18. Funeral director: V. L. Lemperenus.

Address:

19. Jan 23 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-20-1940, at 3:30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-10-1939 to 1-20-1940 and that I last saw him alive on 1-20-1940

Immediate cause of death: Hodgkins Disease — DURATION: 2

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Wm. F. Williams M. D. or other

Address: Cumberland Date signed: Md

Dr Williams
Mr Hilton
5608 Fayette St.

RECEIVED
FEB 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

0034

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 126 Virginia Ave.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 50 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 126 Virginia Ave.
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME Wm. T. Hixon

3. (b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Sue M. Hanmore
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July 5, 1865

8. AGE:

Years	Months	Days	If less than one day
74	6	18	____ hrs. ____ min.

9. Birthplace Spring Gap. Md
(Town, county, and state)
10. Usual occupation Engineer
11. Industry or business B & O Ry

FATHER
12. Name Joseph Hixon
13. Birthplace Hancock Md.

MOTHER
14. Maiden name Hannah Daniel
15. Birthplace Hancock Md.

16. Informant Mrs. John M. Fisher
Address Ft Ashby, W. Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-26-40 (month) (day) (year)
Cemetery or crematory Hillcrest Cem.
Location Cumberland

18. Funeral director Louis Stein Inc.
Address Cumberland

19. Jan. 24 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23 1940, at 11 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 23 1940, to Jan 23 1940, and that I last saw h alive on Jan 23 1940.

Immediate cause of death Coronary Occlusion

Due to Arterio Sclerosis.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Ot operations

Ot autopsy

DURATION
4 hrs
about
2 yrs

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of
Where did injury occur? No
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) No
Means of injury Injured at work?

23. SIGNATURE M. C. Bowers M. D. or other
Address 33 Va Ave Date signed Jan 24 40

RECEIVED
FEB 6 1940
BUREAU V. S.

0035

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52)

WITHIN CORPORATE LIMITS

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 144 E. Main

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Frostburg Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 144 E. Main (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Mary E. Hocking

3. (b) Social Security Number

4. Sex: F

5. Color or race: W

6. (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Oct 17 - 1858

8. AGE: Years: 81 Months: 2 Days: 20 If less than one day ____ hrs. ____ min.

9. Birthplace: Frostburg (Town, county, and state)

10. Usual occupation: house wife

11. Industry or business

FATHER

12. Name: George H. Hocking

13. Birthplace: England

MOTHER

14. Maiden name: Sarah Jane Wareham

15. Birthplace: Md.

16. Informant: Mrs. G. Dud Hocking

Address: Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 8-1940 (month) (day) (year)

Cemetery or ~~crematory~~: Allegany

Location: Frostburg Md.

18. Funeral director: J. J. Durst

Address: Frostburg

19. Jan. 8 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 6, 1940, at 10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 7, 1939, to Jan 6 1940, and that I last saw her alive on Jan 5th, 1940.

Immediate cause of death: Chronic Myocarditis

Due to

Due to

Other conditions: Carcinoma of the bladder. (Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: J. C. Cobey M. D. or other

Address: Frostburg Md. Date signed 1-7-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully ~~be supplied~~. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 3 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

0036

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 514 Frederick St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 40 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany Co.

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 514 Frederick St

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Augustus Hillary Hodges

3. (b) Social Security Number 705-03-9998

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

8 (b) Name of husband or wife Florence Wagner

6(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Dec 12 1873

8. AGE:

Years	Months	Days	If less than one day
66	1	12	____ hrs. ____ min.

9. Birthplace Keyser W. Va.

(Town, county, and state)

10. Usual occupation Master Mechanic

11. Industry or business B & O Ry.

FATHER 12. Name Dalton Hodges

13. Birthplace W. Va.

MOTHER 14. Maiden name Martha E. Curtis

15. Birthplace W. Va.

16. Informant Mrs Florence W. Hodges.

Address Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-27-40 (month) (day) (year)

Cemetery or crematory Queens Point Cem.

Location Keyser, W. Va.

18. Funeral director Louis Stein Inc.

Address Cumberland

19. Jan. 26, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1940, at 9:50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 13 1939, to Jan. 24 1940, and that I last saw him alive on Jan 24 1940

	DURATION
Immediate cause of death Cerebral Hemorrhage (Right)	1 hour
Due to Hypertension Cardio vascular Renal disease	3 yrs est ? ?
Due to and Coronary	
Artery sclerosis	3 yrs ? ?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel A. Jarboe M.D. M. D. or other

Address 119 Bedford St Date signed 1/25/40

RECEIVED
FEB 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

0037

Reg. Diat. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 4 Altamont Terrace
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) Lifetime

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 4 Altamont Terrace
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR Spanish American

3. (a) FULL NAME John Henry Hoffman

3. (b) Social Security Number 705-09-5516

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Dora Kesecker Hoffman
6(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Feb 12, 1876

8. AGE: Years	Months	Days	If less than one day
63	11	11	hrs. min.

9. Birthplace Cumberland (Town, county, and state)
10. Usual occupation Railroad Conductor-Retired
11. Industry or business Railroad.

FATHER
12. Name Melancton Hoffman
13. Birthplace Cumberland

MOTHER
14. Maiden name Annie Bell
15. Birthplace Cumberland

16. Informant Dora Hoffman
Address 4 Altamont Terrace

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 25 1940 (month) (day) (year)
Cemetery or crematory Hillcrest Cemetery
Location Cumberland, Maryland
18. Funeral director Jacob Hafer
Address Cumberland Md.
19. Jan 25, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-23- to 1940

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-23- to 1-23-1940
and that I last saw him alive on 1-23-40 19

Immediate cause of death	DURATION
Acute Myocarditis	Hours
Due to ?	
Due to Chronic Myocarditis	?
Other conditions None	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. C. Zimmerman M. D. or other
Address Cumberland Md. Date signed Jan 1-25-40

Dr. Zimmerman

RECEIVED
FEB 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

0038

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 901 Layafette Ave.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 901 Lafayette Ave.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mrs. Miranda Lee House

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	White	Married

6 (b) Name of husband or wife: Thomas E. House

6(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): June 21, 1862

8. AGE: Years	Months	Days	If less than one day
77	7	6	hrs. min.

9. Birthplace: West Va. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Absolam Wagoner

13. Birthplace: W. Va.

MOTHER

14. Maiden name: Eliza Feeney

15. Birthplace: W. Va.

16. Informant: Mrs. John McArdle

Address: 646 Fayette St. Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 29, 1940 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland

18. Funeral director: J. C. Wolford

Address: Cumberland, Md.

19. Jan. 28, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 27, 1940, at 12:0 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1939, to January 1940, and that I last saw h- alive on January 26 1940.

	DURATION
Immediate cause of death: Chronic Myocarditis	Unknown
Duration: Five years.	
Due to: C.V.D.	
Due to:	
Other conditions: Arteriosclerosis	Unknown

(Include pregnancy within 3 months of death)

Major findings:

Dt operations:

Dt autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: James T. Johnson Jr. M. D. or other

Address: Cumberland, Md. Date signed: 1-27-40

RECEIVED
FEB 6 1940
BUREAU V. S.

0039

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany

City or town Westernport Md
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 87 Main

Stay in hospital or inst. (yrs., or mos., or days) ~~74-7-5~~

Stay in this community (yrs., or mos., or days) 74-7-5

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Westernport Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 87 Main St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Levania Ann Hughes

3. (b) Social Security Number: None.

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Jacob W. Hughes

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): June 14 1865

8. AGE: Years 74 | Months 7 | Days 5 | If less than one day ____ hrs. ____ min.

9. Birthplace: Garrett County, Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER
12. Name: William Kight
13. Birthplace: Garrett Co. Md

MOTHER
14. Maiden name: Levania Ann Kight
15. Birthplace: Garrett County, Md

16. Informant: C. W. Hughes
Address: 87 Main St Westernport Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 22, 1940 (month) (day) (year)

Cemetery or crematory: Philos

Location: Westernport Md

18. Funeral director: Boal

Address: Westernport Md

19. Jan 22 1940 (Date rec'd by registrar) A J Saxenbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19th 1940, at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 1940, to Jan 19 1940, and that I last saw her alive on Jan 19 1940.

Immediate cause of death: acute myocardial failure

Due to: Chronic myocarditis. Duration - not stated. C.W.G.R.

Due to

Other conditions: Pulmonary edema
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: C W Reeves M.D. (M. D. or other)

Address: Westernport Md Date signed 1/21/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1940
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (159)

Reg. Dist. No. 9

0040

WITHIN CORPORATE LIMITS

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Frostburg
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Miners Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) ½ day
(e) Length of stay in this community (yrs., mos., or days) ½ day

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Allegany
(c) City or town Zilhman
(If outside city or town limits, write RURAL and give town)
(d) Street No. _____
(If rural give location)
(e) If foreign born, how long in U. S. A.? _____ years

3 (a) **FULL NAME** Baby Johnson

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	—

6 (b) Name of husband or wife —

6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1/10/40

8. AGE: Years	Months	Days	If less than one day
		½	_____hr. _____min.

9. Birthplace Zilhman
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name Harold Johnson
13. Birthplace Zilhman, Md

MOTHER
14. Maiden Name Ann M. Kempert
15. Birthplace Greensburg, Pa

16 (a) Informant Mrs Harold Johnson
(b) Address Zilhman, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 11, 1940 (month) (day) (year)
(c) Cemetery or crematory Porter Cemetery
Location Eckhart, Md.

18 (a) Funeral director Jacob Blaker.
(b) Address Frostburg, Md.

19 (a) 1-11-40 (Date rec'd by registrar) (b) Mrs. A. B. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death 1/11/40 19___, at 3 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10/40 19___, to 1/11/40 19___, and that I last saw him alive on 1/10/40 19___.

Immediate cause of death	Duration
PREMATURITY	
Due to	
Due to	
Other conditions (6 MONTHS PREGNANCY) (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? [redacted] (Specify type of place) While at work?
(e) Means of injury

23. Signature John Kilday. M.D. (M. D. or other)
Address 56 W. Main St. Frostburg Md. Date signed 1/11/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (181)

CERTIFICATE OF DEATH

0041

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days): 2 days.

Stay in this community (yrs., or mos., or days): 1 yr 6 mo

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 218 Columbia St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Loretta Lee Joy

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug 28 1938

8. AGE:

Years	Months	Days	If less than one day
1	4	16	hrs. min.

9. Birthplace: Cumberland Allegany Co. Md (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER 12. Name: Floyd C. Joy

13. Birthplace: Brunswick Md

MOTHER 14. Maiden name: Bessie Jones

15. Birthplace: Cumberland Md.

16. Informant: Floyd C Joy

Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-16-40 (month) (day) (year)

Cemetery or crematory: Hillcrest Cem.

Location: Cumberland Md

18. Funeral director: Louis Stein Inc.

Address: Cumberland, Md.

19. Jan. 16 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

Jacobson

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14 1940, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 12 1940, to Jan 14 1940, and that I last saw h alive on Jan 14, 1940.

Immediate cause of death: Acute Pulmonary Edema

Due to: Cardiac Failure

Due to: Third Degree Burns of body

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION

Acute Pulmonary Edema —

Cardiac Failure —

Third Degree Burns of body 2 days

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Accident Date of: Jan. 12, 1940

Where did injury occur? Cumberland, Allegany, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Fell in tub of H+X Water Injured at work? No

23. SIGNATURE: Samuel Jacobson, M.D. M. D. or other

Address: 119 Bedford St. Date signed 1/15/40

RECEIVED
FEB 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-a)

0042

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 27 Race St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 40 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 27 Race St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Catherine G. Kastner

3. (b) Social Security Number None.

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank Kastner

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): July 18-1879

8. AGE: Years 60 | Months 6 | Days 4 | If less than one day ____ hrs. ____ min.

9. Birthplace: Bloomington, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at Home.

FATHER

12. Name: Peter Cordire

13. Birthplace: Ireland

MOTHER

14. Maiden name: Mary Clancey

15. Birthplace: Ireland

16. Informant: Frank Kastner

Address: Cumberland Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof 1-25-40 (month) (day) (year)

Cemetery or crematory: St. Peter & Pauls Cem

Location: Cumberland Md.

18. Funeral director: Louis Stein Inc.

Address: Cumberland

19. Jan. 24, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/22/40 19____, at 3:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/7/37 19____, to 1/22/40 19____, and that I last saw h____ alive on ____ 19____.

Immediate cause of death: Carcinomatosis in abdomen

Due to: Primary Carcinoma of cervix of uterus. C.W.G.R.

Due to: Duration: three years.

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Dt operations

Dt autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE John K Rozner MD M.D. or other

Address Cumberland Md Date signed 1/24/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

I

(T)

RECEIVED
FEB 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

0043

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany

Stay in hospital or inst. (yrs., or mos., or days): 12 hrs.

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pa. County: Bedford

City or town: Hyndman Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ✓

3. (a) FULL NAME: Baby Boy Kerr

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Single

B (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 1-22-40

8. AGE: Years | Months | Days | If less than one day: 12 hrs. 30 min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: John Mason Kerr

FATHER — 13. Birthplace: Manns Choice Pa.

MOTHER — 14. Maiden name: Helen Kathryn Martz

MOTHER — 15. Birthplace: Hyndman, Pa.

16. Informant: Mrs. Kathryn Kerr.

Address: Hyndman, Pa

17. Removal & Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 23, 1940 (month) (day) (year)

Cemetery or crematory: Hyndman Cem

Location: Hyndman, Penna

18. Funeral director: Harvey A. Beigles

Address: Hyndman Penna

19. Jan. 23, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 22, 1940, at 9:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 22, 1940, to Jan 22, 1940, and that I last saw him alive on Jan 22, 1940.

Immediate cause of death	DURATION
Premature Infant,	
Due to 7 month gestation	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: John A. Topper, M. D. or other

Address: Hyndman Pa Date signed: Jan 23, 1940

RECEIVED
FEB 6 1940
BUREAU V. ...

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (126)

CERTIFICATE OF DEATH

0044

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: ~~1776~~ Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 33 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 39 Humbird Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME Eleanor Jane Ketzner
Eleanor Jane Ketzner

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: John Ketzner
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 30, 1903

8. AGE:

Years	Months	Days	If less than one day
33	4	1	hrs. min.

9. Birthplace: Cumberland, Maryland
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At home

FATHER
12. Name: James C. Riley
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Cesetia Ambrose
15. Birthplace: West Virginia

16. Informant: Gerald C. Riley
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 4, 1940 (month) (day) (year)
Cemetery or crematory: St. Patrick Cemetery
Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.

19. Jan 3 (Date rec'd by registrar) 19 40 J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-1-40 (19), at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-27-39 19, to 1-1-40 19, and that I last saw her alive on 1-1-40 19

Immediate cause of death: Cholelithiasis — DURATION: 2

Due to: ~~Stone~~ ?

Due to:

Other conditions: Toxemia — 3 days
2½ mo. pregnancy
(Include pregnancy within 3 months of death)

Major findings:
Of operations: Cholelithiasis
Of autopsy: none made

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: C. G. Zimmerman M. D. or other
Address: [illegible] Date signed: 1-2-40

RECEIVED
FEB 6 1940
BUREAU V. S.

0045

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Clarysville, Md (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Clarysville, Md

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 12 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Clarysville Ward No.: Rural (If outside city or town limits, write RURAL NEAR and give town)

Street No.: near Frostburg (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: John William Kreitzburg

3. (b) Social Security Number: 701-07-2491* ~~None~~ Ross

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Sarah A. Kreitzburg

6(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Sept 11 1874

8. AGE:

Years	Months	Days	If less than one day
65	4	19	hrs. min.

9. Birthplace: Eckhart Md (Town, county, and state)

10. Usual occupation: Mine Foreman

11. Industry or business: Coal Mines

FATHER
12. Name: John Kreitzburg
13. Birthplace: Germany

MOTHER
14. Maiden name: Mary Baskey
15. Birthplace: ?

16. Informant: Sarah A. Kreitzburg

Address: Clarysville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 2, 1940 (month) (day) (year)

Cemetery or crematory: Porter Cemetery

Location: Eckhart, Md

18. Funeral director: Jacob Hofer

Address: 23 E. Main St. Frostburg Md.

19. Feb. 2nd 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 30 1940, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 10 1940, to Jan. 30 1940, and that I last saw h im alive on Jan 30 1940.

Immediate cause of death: Hypertensive cardio-vascular renal disease. — DURATION: 10 yrs.

Due to:

Due to:

Other conditions: arterio-sclerosis. — 10 yrs.

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. C. Diehl, M.D. M. D. or other

Address: Frostburg, Md. Date signed: 2/1/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 3 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55.D

0046

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 3 mos.

Stay in this community (yrs., or mos., or days) 3 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 324 Furnace St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Barbara Ann Laing

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Child

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1936

8. AGE: Years	Months	Days	If less than one day
3	3	22	hrs. min.

9. Birthplace Cumberland, Allegany, Md

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Wm. H. Laing

13. Birthplace Cumberland, Md.

MOTHER 14. Maiden name Margaret McDade

15. Birthplace Bell Pa.

16. Informant Wm. H. Laing

Address Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 26, 1940 (month) (day) (year)

Cemetery or crematory St Peters & Paula

Location Cumberland, Md

18. Funeral director Jacob Hafer

Address Cumberland.

19. Jan. 26 1940 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23, 1940, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 24, 1939, to January 23 1940, and that I last saw her alive on January 23 1940.

Immediate cause of death Intercranial pressure — DURATION

Due to Invasion of new growth.

Due to Retino-blastoma.

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations Right eyeball enucleated on May 4, 1939, retino-blastoma. 1/24/40: Intercranial pressure

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L E Daugherty M.D. M. D. or other

Address Cumberland Md Date signed 1-26-40

FL One 26-

RECEIVED
FEB 8 1940
BUREAU V. S.

Dr. Williams

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

CERTIFICATE OF DEATH

0047

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
537 Columbia Ave.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 537 Columbia Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Agnes E. Leasure

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	White	Widowed

6 (b) Name of husband or wife Layafette Leasure

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 14, 1861

8. AGE: Years	Months	Days	If less than one day
78	9	10	hrs. min.

9. Birthplace Allegany Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Levi Hamilton

13. Birthplace Maryland

MOTHER 14. Maiden name Melvina Wolford

15. Birthplace Maryland

16. Informant Miss. Olive Leasure

Address 537 Columbia Ave. Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 26, 1940 (month) (day) (year)

Cemetery or crematory Union Grove Cem.

Location Near Cumberland

18. Funeral director J. C. Wolford

Address Cumberland, Md.

19. Jan. 25 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24, 1940, at 1240 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-21-1940 to 1-24-1940, and that I last saw h[illegible] alive on 1-23-1940.

	DURATION
Immediate cause of death Bronchopneumonia	
Due to Chronic Myocarditis ?	
Due to Chronic Endocarditis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. F. Williams M. D. or other

Address Cumberland Date signed 1-25-40

RECEIVED
FEB 8 1940
BUREAU V. R.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

0048

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Frostburg
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Miners Hospital

Stay in hospital or inst. (yrs., or mos., or days) 2 Hours

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Midland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. ←
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ←

3. (a) FULL NAME Robert F. Loar

3. (b) Social Security Number 2401-2104

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Lucy Hamman Loar

6(c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) April 15 - 1872

8. AGE: Years	Months	Days	If less than one day
68	9	3	hrs. min.

9. Birthplace Midland, Md
(Town, county, and state)

10. Usual occupation W. P. A. Worker

11. Industry or business Savage River Dam

FATHER 12. Name George Loar

FATHER 13. Birthplace Vale Summit, Md

MOTHER 14. Maiden name Mary Barnard

MOTHER 15. Birthplace Frostburg, Md

16. Informant John R. Loar

Address Midland, Md

17. Burial Date thereof Jan. 22, 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md

18. Funeral director M. Eichhorn

Address Lonaconing, Md

19. Jan. 20 1940 Mrs. A. R. Walker
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18 1940, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 18 1940, to Jan. 18 1940, and that I last saw him alive on Jan. 18 1940.

Immediate cause of death	DURATION
Lobar Pneumonia	7 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Ot operations

Ot autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. E. Gatten M. D.
M. D. or other

Address Frostburg, Md. Date signed 1/20/40

RECEIVED
FEB 2 1949
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (112)

CERTIFICATE OF DEATH

0049

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 143 N. Mechanic St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 10 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 143 N Mechanic
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Irvin Ruben Lohr

3. (b) Social Security Number

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Emma Lohr Lohr

6(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) June 1, 1884

8. AGE: Years 65 Months 7 Days 19 If less than one day ____ hrs. ____ min.

9. Birthplace Reity Pa.
(Town, county, and state)

10. Usual occupation Auto Salvage

11. Industry or business Own business

FATHER
12. Name Harrison Lohr
13. Birthplace Hooversville Pa

MOTHER
14. Maiden name Martha Wolfred
15. Birthplace Holsopple, Pa.

16. Informant Ernest Lohr
Address Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 23 1940 (month) (day) (year)
Cemetery or crematory Hillcrest Cemetery
Location Cumberland, Md.

18. Funeral director Jacob Hafer
Address Cumberland Md

19. Jan 23 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20th 1940, at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 1940 to Jan 20th 1940, and that I last saw him alive on Jan 20 1940.

Immediate cause of death	Congestive failure	DURATION
Due to		
Due to		
Other conditions	Bronchial Asthma	

(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. V. Compton M. D. or other
Address 5 E. N. Mech. Date signed 1-22-40

RECEIVED
FEB 6 1940
BUREAU V. F.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

191-8

CERTIFICATE OF DEATH

0050

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 9 days

Stay in this community (yrs., or mos., or days) Lifetime

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town R.F.D. #5 Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Potomac Park

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Jacob Francis Luteman

3. (b) Social Security Number 214-16-2826

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 9, 1900

8. AGE:

Years	Months	Days	If less than one day
39	4	1	hrs. min.

9. Birthplace Cumberland, Allegany, Maryland (Town, county, and state)

10. Usual occupation W.P.A. Worker

11. Industry or business

FATHER

12. Name Albert Luteman

13. Birthplace Oldtown, Md

MOTHER

14. Maiden name Florence Dougherty

15. Birthplace Cumberland, Md

16. Informant Blanche Luteman

Address Potomac Park

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 1, 1940 (month) (day) (year)

Cemetery or crematory St. Patrick's Cemetery

Location Cumberland, Md

18. Funeral director Jacob Hofer

Address 730 Baltimore Ave.

19. Jan. 31, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 1940, at 2A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 22 1940, to January 30 1940, and that I last saw him alive on January 29 1940.

	DURATION
Immediate cause of death Uremia	?? 4 mo.
Due to Chronic Glomerulo Nephritis	???
Due to Hypertension — Secondary Uremia	??? ??
Other conditions Malnutrition	??

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel Jacobs M.D. M. D. or Other

Address 119 Bedford St. Date signed 1/30/40

RECEIVED
FEB 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92E)

0051

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) 1 Day

Stay in this community (yrs., or mos., or days) 19 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 513 VALLEY ST.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: MRS. ANNA MAE MARTIN

3. (b) Social Security Number

4. Sex: FEMALE

5. Color or race: WHITE

6. (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: LEONARD W. MARTIN

6(c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.): July 17, 1912

8. AGE: Years ~~26~~ 27 | Months 5 | Days 21 | If less than one day ____ hrs. ____ min.

9. Birthplace MD. Mt Savage (Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business At Home

FATHER
12. Name TWIGG, ELZA
13. Birthplace MD. Red Hill

MOTHER
14. Maiden name JENKINS, ELIZABETH
15. Birthplace MD. Mt Savage

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 10, 1939 (month) (day) (year)

Cemetery or crematory Episcopal Cem.

Location Mt Savage, Md

18. Funeral director Jacob Hofer

Address Cumberland, Md.

19. Jan. 10, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. ZIMMERMAN

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 8, 1940 3:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1938, to 1-8-40 19__, and that I last saw her alive on 1-8-40 19__.

Immediate cause of death: Mitral insufficiency — DURATION: 2

Due to 2.

Due to 2.

Other conditions: Pulmonary edema — 2 Day

(Include pregnancy within 3 months of death)

Major findings:

Of operations: None

Of autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of Injury ____ Injured at work?

23. SIGNATURE [signature] M. D. or other

Address [illegible] Date signed 1-9-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

I (T)

RECEIVED
FEB 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

0052

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Memorial Hospital

City or town: Cumberland, Maryland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days): 2½ hours

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 444 Central Avenue

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

Baby boy Martz (Premature)

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife: None

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 16, 1940

8. AGE:

Years	Months	Days	If less than one day
			2 hrs. 30 min.

9. Birthplace: Cumberland, Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER

12. Name: Homer Martz

13. Birthplace: West Virginia

MOTHER

14. Maiden name: Esther Ehrhardt

15. Birthplace: Pennsylvania

16. Informant: Memorial Hospital

Address

17. Memorial Hospital (Burial, cremation, or removal. Which?) Date thereof Jan 17/40 (month) (day) (year)

Cemetery or crematory

Location: Cremated Memorial Hosp.

18. Funeral director

Address

19. Jan. 17 1940 (Date rec'd by registrar) J. P. Franklin M. D. Registrar

DR. REYNOLDS

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 16, 1940, at 10:15 AM PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 16 /40 19, to Jan 16/40 19, and that I last saw him alive on Jan 16/40 19.

Immediate cause of death: Prematurity

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Eugene Reynold M D M. D. or other

Address: Medical Bldg. Date signed: Jan 17/40

RECEIVED
FEB 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

0053

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL, NEAR and give town)
Street address, hospital, or institution: 12 Fourth St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL, NEAR and give town)
Street No. 12 Fourth St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Stillborn Mattingly

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
?	White	Single

6 (b) Name of husband or wife
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) January 14 1940

8. AGE: Years | Months | Days | If less than one day ____ hrs. ____ min.
Stillborn

9. Birthplace Cumberland, Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Francis DeSales Mattingly
13. Birthplace Cooke Mills, Penna

MOTHER
14. Maiden name Sylvia Genevieve Drakenstein
15. Birthplace Cumberland, Md.

16. Informant Francis DeSales Mattingly
Address 12 Fourth St., City

17. Cremation
(Burial, cremation, or removal. Which?) Date thereof Jan. 14, 1940 (month) (day) (year)

Cemetery or crematory Cremation
Location at the

16. Funeral director Home
Address Cumberland, Md.

19. Jan 16 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 14 1940, at 0 5 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____, and that I last saw h____ alive on ____ 19____.

Immediate cause of death Stillborn — DURATION 3 mos

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. N. Trevaskis M D
M. D. or other
Address Date signed

RECEIVED
FEB 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

0054

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 404 E Fourth St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 50 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 404 E. Fourth

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME George H. McCracken

3. (b) Social Security Number None

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Ida. Leech.

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Oct 21 1857

8. AGE: Years 82 | Months 3 | Days 4 | If less than one day ____ hrs. ____ min.

9. Birthplace: Wilmington Del.

(Town, county, and state)

10. Usual occupation: ~~[illegible]~~ Laundry owner

11. Industry or business

FATHER

12. Name: John McCracken.

13. Birthplace: Del.

MOTHER

14. Maiden name: Mary E. Selby.

15. Birthplace: Del.

16. Informant: Geo H McCracken Jr.

Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-28-40 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland.

18. Funeral director: Louis Stein Inc.

Address: Cumberland

19. Jan 28, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 25 1940, at 6 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Jan 2 1940, to Jan 25 1940, and that I last saw him alive on Jan 20 1940.

Immediate cause of death: Coronary occlusion

Due to: Arterio sclerosis.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

DURATION: about 2 yr

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): no

Means of injury Injured at work?

23. SIGNATURE: M E B Owens M. D. or other

Address: 133 Va ave Date signed 1/29/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

0055

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 220 Washington St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 220 Washington
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs. Mary Esther McEvoy

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Fem.	White	Widowed

6 (b) Name of husband or wife Charles H. McEvoy

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1872

8. AGE:

Years	Months	Days	If less than one day
67	4	29	____ hrs. ____ min.

9. Birthplace Washington, Iowa
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Robert Shearer
13. Birthplace Maryland

MOTHER
14. Maiden name Sue Winter
15. Birthplace Maryland

16. Informant Mrs. Sue Brett

Address 220 Washington St. Cumberland

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof Jan. 12, 1940
(month) (day) (year)

Cemetery or crematory St. Micheal Cem.

Location Frostburg, Md.

18. Funeral director J. C. Wolford

Address Cumberland, Md.

19. Jan. 11, 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10, 1940, at 7 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 28 1940, to Jan. 10 1940, and that I last saw her alive on January 10 1940.

Immediate cause of death Myocarditis

DURATION 13 dys

Due to The myocarditis was Chronic. Duration: Unknown C.W.G.R.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James T. Johnson Jr.
M. D. or other

Address Cumberland Date signed 1-11-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-a)

CERTIFICATE OF DEATH

0056

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Allegheny

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 114 So Smallwood St

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegheny

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 114 So. Smallwood St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME James Claude Mc Kenzie

3. (b) Social Security Number 214-05-5012

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Mary Mc Dermott

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) January 27, 1887

8. AGE: Years	Months	Days	If less than one day
53	0	2	____ hrs. ____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Engineer

11. Industry or business Kelmon Brewery

FATHER 12. Name Nicholas Mc Kenzie

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Marion Miller

MOTHER 15. Birthplace Maryland

16. Informant Miss Mary McKenzie

Address 114 So Smallwood St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 1 - 1940 (month) (day) (year)

Cemetery or crematory St Peter & Paul

Location Cumberland Md

18. Funeral director Virgil L. Dempsey

Address Cumberland Md

19. Jan. 31, 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 1940, at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 21 1939, to Jan 29 1940, and that I last saw h alive on Jan 29 - 1940.

	DURATION
Immediate cause of death: Internal Hemorrhage (Gastro-Intestinal)	36 hrs
Due to Pernicious Anemia	
Due to The gastro-intestinal hemorrhage was due to the pernicious anemia	
Other conditions C.W.S.R.	

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. P. Matthews M. D. or other

Address 101 So Centre St Date signed 1/30/40

RECEIVED
FEB 8 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

0057

CERTIFICATE OF DEATH

Reg. Dist. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Barton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 57 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Barton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Jefferson Watson Metz

3. (b) Social Security Number 212-03-3841

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Blanche Snakey Metz
6 (c) If alive, give age: 50 years
7. Birth date of deceased (mo., day, yr.): October 6, 1882
8. AGE: Years: 57 Months: 3 Days: 6 If less than one day: hrs. min.
9. Birthplace: Barton, Allegany, Md. (Town, county, and state)
10. Usual occupation: Driver for (janitor)
11. Industry or business: Clarence Coal Co.
FATHER
12. Name: William Metz
13. Birthplace: Barton, Md
MOTHER
14. Maiden name: Amy Ellen Poland
15. Birthplace: Barton, Md
16. Informant: Mrs. Blanche Metz
Address: Barton Md
17. Burial (Burial, cremation, or removal Which?) Date thereof Jan. 14, 1940 (month) (day) (year)
Cemetery or crematory: Laurel Hill
Location: Morgan, Md.
18. Funeral director: D. S. Brady
Address: Barton, Md.
19. Jan 13 1940 (Date rec'd by registrar) S. A. Boucher Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 12, 1940, at 6:00 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 8, 1940, to Jan 12, 1940, and that I last saw him alive on Jan 11 1940

Immediate cause of death — DURATION
Chronic Myocarditis — 6 mos
Chronic Bronchitis — 4 yrs.
Due to Anthracosis — 4 yrs
Due to Working in Coal mines

Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE J. Norman Reeves, M.D.
M. D. or other
Address Westernport, Md. Date signed 1-14-40

RECEIVED
FEB 5 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 93-21

Reg. Dist. No. 10

0058

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Mt Savage (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 2 yr 6 mos

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Allegany

(c) City or town Mt Savage Md (If outside city or town limits, write RURAL and give town)

(d) Street No. — (If rural give location)

(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Louis W. Miller.

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Mary Miller

6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 10. 1857

8. AGE: Years 82 Months 2 Days 19 If less than one day ___ hr. ___ min.

9. Birthplace Cumberland Allegany Md (Town, county and state)

10. Usual occupation Retired upholsterer

11. Industry or business Upholsting Furniture

FATHER

12. Name Christopher Miller.

13. Birthplace Germany

MOTHER

14. Maiden Name Katharine Metzger

15. Birthplace Germany

16 (a) Informant Mrs Ruth C Arnold

(b) Address Mt Savage Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 1-1940 (month) (day) (year)

(c) Cemetery or crematory German Lutheran Cem.

Location Cumberland Md.

18 (a) Funeral director Louis Steier Inc.

(b) Address Cumberland Md.

19 (a) Jan 31-1940 (Date rec'd by registrar) (b) H. J. Bostetter M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death Jan 29 1940, at 11:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1938, to Mar. 1939, and that I last saw him alive on Mar 20 1939.

Immediate cause of death Myocardial Weakness acute dilatation

Due to

Due to

Other conditions Senile Dementia (Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. J. Bostetter M.D. M. D. or other

Address Mt Savage Md Date signed 1/31-40

RECEIVED
FEB 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

0059

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Sylvan Retreat

Stay in hospital or inst. (yrs., or mos., or days): 3 yrs.

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Westernport Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Greens Addition
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Harriett Catherine Murphy

3. (b) Social Security Number:

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: ~~Married~~ Widowed

6 (b) Name of husband or wife: Jno. Thos. Murphy

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 18 - 1853

8. AGE: Years 83 | Months 3 | Days 20 | If less than one day ____ hrs. ____ min.

9. Birthplace: F Garrett Co. near Frostburg Md.
(Town, county, and state)

10. Usual occupation: Homework

11. Industry or business: Own Home

FATHER
12. Name: Jno. La Rue
13. Birthplace: not Known

MOTHER
14. Maiden name: Rebecca Durst
15. Birthplace: Frostburg Md.

16. Informant: Mrs. Thomas Trezise
Address: Westernport Md.

17. Burial
(Burial, cremation, or removal, Which?)
Date thereof: Jan. 10 - 1940 (month) (day) (year)

Cemetery or crematory: Blucher Cemetery

Location: Garrett Co. near Frostburg Md.

18. Funeral director: David S. Boal
Address: Westernport, Md.

19. Jan. 8, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 - 7 - 1940, at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12. 1. 1939, to 1 - 7 - 1940, and that I last saw her alive on 1 - 5 - 1940.

Immediate cause of death: Arterio sclerosis — DURATION: ?

Due to:

Due to:

Other conditions:
(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm F. Williams M. D. or other

Address: Cumberland Date signed: 1-8-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M) (T) I

RECEIVED
FEB 6 1940
BUREAU V. S.

0060

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157-8

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH:

County Allegany

City or town Moscow
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 1 Mo. 23 dr

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary Lou Murphy

3. (b) Social Security Number None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26 1939

8. AGE: Years | Months 1 | Days 23 | If less than one day hrs. min.

9. Birthplace Westernport Allegany, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name William J. Murphy
13. Birthplace Franklin, Md

MOTHER
14. Maiden name Audrey Morgan
15. Birthplace Lansing, Ohio

16. Informant W. J. Murphy
Address Piedmont, W. Va

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Jan 20, 1940 (month) (day) (year)

Cemetery or crematory St. Peters

Location Westernport, Md.

18. Funeral director D. S. Boal
Address Barton, Md.

19. Jan 19 1940 S. A. Boucher
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18 1940, at 5a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 26 1939, to Jan 18 1940 and that I last saw him alive on Jan 18 1940.

Immediate cause of death Spinal Bifida

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:

Dt operations

Dt autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M.D.
M. D. or other

Address Westernport Md. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

0061

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 213 Fayette St.

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 75 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 213 Fayette (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Mrs Margaret Neff.

3. (b) Social Security Number: none

4. Sex: F.

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name ~~of husband~~ or wife: of Late Edward R.

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): August 12 - 1855

8. AGE: Years: 84 Months: 5 Days: 0 If less than one day ____ hrs. ____ min.

9. Birthplace: Penna (Town, county, and state)

10. Usual occupation: At Home

11. Industry or business: House Wife

FATHER

12. Name: Alexander McKee

13. Birthplace: Penna

MOTHER

14. Maiden name: Margaret Halliday

15. Birthplace: Penna

16. Informant: Thomas A. Neff

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 15-39 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland Md

18. Funeral director: V. L. Lemperer

Address: Cumberland, Md.

19 Jan. 13 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 12, 1940, at 9:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 11th 1940, to Jan 12th 1940, and that I last saw her alive on Jan 12th 1940.

Immediate cause of death: Acute Broncho Pneumonia — DURATION: 2 days

Due to

Due to

Other conditions: Cerebral Edema — 1 day

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: C. L. Owens M. D. or other

Address: Cumberland Md Date signed: Jan 12-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

I

Mr Owens

Miss Margaret Neff.
213 Hazelle Pl.

RECEIVED
FEB 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

0062
4
Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 128 South St
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 2 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 128 South St
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary Fanny Newlon

3. (b) Social Security Number None

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Albert S. Newlon
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): April 23, 1850

8. AGE: Years: 84 | Months: 9 | Days: 0 | If less than one day: — hrs. — min.

9. Birthplace: Culpepper, Culpepper-Va (Town, county, and state)

10. Usual occupation: House-work

11. Industry or business: —

FATHER
12. Name: James Carson Grove
13. Birthplace: Culpepper, Va.

MOTHER
14. Maiden name: Susan Tapp.
15. Birthplace: Culpepper, Va

16. Informant: H. D. Newlon
Address: 425 Bell St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 26 1940 (month) (day) (year)
Cemetery or crematory: Parish Cem.
Location: Westernport, Md

18. Funeral director: D. S. Boal
Address: Westernport, Md

19. Jan. 24, 40 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23, 1940, at 7.50 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 18, 1940, to Jan. 23, 1940, and that I last saw her alive on Jan. 23, 1940.

	DURATION
Immediate cause of death: Generalized Atherosclerosis	1930
Due to: Chronic Myocarditis	1935
Due to: Bronchial Asthma	1/10/40
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE Clay E. Jones M. D. or other
Address Cumberland, Md. Date signed Jan. 24, 1940

RECEIVED
FEB 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

0063

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 400 Walnut Street

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 40 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 400 Walnut Street
(If rural, give LOCATION)

2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: James Edward O'Hara

3. (b) Social Security Number: None Does 548-07-2900

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Minnie Ames

6(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): January 12, 1880

8. AGE: Years: 60 Months: 0 Days: 3 If less than one day: hrs. min.

9. Birthplace: Eckhart Allegany, Maryland
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Police

FATHER
12. Name: Dennis O'Hara
13. Birthplace: Unknown

MOTHER
14. Maiden name: Jeanette Nelson
15. Birthplace: Scotland

18. Informant: Mrs. Minnie Ames O'Hara
Address: 400 Walnut Street, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: January 27, 1940 (month) (day) (year)

Cemetery or crematory: St. Patrick Cemetery

Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Maryland

19 Jan. 26, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 24 1940, at 11:55 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15 1940, to Jan. 24 1940, and that I last saw h[illegible] alive on Jan. 23 1940.

	DURATION
Immediate cause of death: Congestive Cardiac Failure	9 days
Due to: Chronic Myocarditis	3 yrs.
Due to:	
Other conditions: Cerebral Arteriosclerosis	3 yrs.

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Arthur F. Ames Jr. M.D.
M. D. or other

Address: 402 N. Liberty St. Date signed: 1-25-40

RECEIVED
FEB 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS,

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (123)

CERTIFICATE OF DEATH

0064

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) One day

Stay in this community (yrs., or mos., or days) 13 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 108 Baca Ave.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Richard A. Olson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Infant

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 11, 1938

8. AGE: Years | Months: 13 mo. | Days: 2 | If less than one day: hrs. min.

9. Birthplace Cumberland, Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name George Olson

FATHER 13. Birthplace Cumberland Md.

MOTHER 14. Maiden name Virginia Perky

MOTHER 15. Birthplace Cumberland, Md.

16. Informant Allegany Hospital

Address Decatur Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 31, 1940 (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland Md.

18. Funeral director Harvey H. Zeigler

Address Frostburg, Pa.

19. Jan. 30, 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-29-40, 19, at 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-28-40, 19, to 1-29-40, 19, and that I last saw h[illegible] alive on 1-29-40, 19.

Immediate cause of death: Intestinal Obstruction — DURATION

from Meckels diverticulitis 2 wks

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings: Infected Diverticulum

Of operations: Meckels Causing obstruction

Of autopsy: None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE W. Alfred Vance

M. D. or other

Address Cumb. Md. Date signed 1-30-40

RECEIVED
FEB 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

CERTIFICATE OF DEATH

0065

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 78 Humbird St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 78 Humbird
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Claude Wellington Orndorff

3. (b) Social Security Number None 708-09-9772

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Margaret Donaldson

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28 1876

8. AGE: Years	Months	Days	If less than one day
63	8	25	hrs. min.

9. Birthplace Springfield W. Va.
(Town, county, and state)

10. Usual occupation Machinist Helper.

11. Industry or business B & O Ry

FATHER 12. Name Henry H Orndorff.

13. Birthplace W. Va.

MOTHER 14. Maiden name Harriett Everett.

15. Birthplace W. Va.

16. Informant Wm. Orndorff.

Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-25-40 (month) (day) (year)

Cemetery or crematory Greenmount Cem.

Location Cumberland Md.

18. Funeral director Louis Stein Inc.

Address Cumberland.

19. Jan 24 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1940, at M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from July 20 1935, to Jan 23 1940, and that I last saw him alive on Jan 22 1940.

	DURATION
Immediate cause of death Chronic Valvular Heart disease	5 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [illegible] M. D. or other

Address [illegible] Va Date signed Jan 29 1940

RECEIVED
FEB 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

0066

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: MEMORIAL HOSPITAL
Stay in hospital or inst. (yrs., or mos., or days) 16 days
Stay in this community (yrs., or mos., or days) 40 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD. County ALLEGANY
City or town CUMBERLAND Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 220 N. Lee St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME James S Patterson

3. (b) Social Security Number None

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Elizabeth Wilson Patterson
6(c) If alive, give age: 64 years
7. Birth date of deceased (mo., day, yr.): November 22, 1868
8. AGE: Years 71 | Months 1 | Days 29 | If less than one day: hrs. min.
9. Birthplace: PA. (Town, county, and state)
10. Usual occupation: RETIRED
11. Industry or business: Mail carrier
FATHER 12. Name: PATTERSON, J.W.
13. Birthplace: PA.
MOTHER 14. Maiden name: LYON, MARGARET
15. Birthplace: PA.
16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND? MD.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 23, 1940 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland, Maryland
18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland
19. Jan. 22 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. TOLSON

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20 1940, at 5:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-4- 1940, to 1-20- 1940, and that I last saw him alive on 1-20- 1940.

	DURATION
Immediate cause of death: Myocardial Degeneration,	?
Due to: Arteriosclerosis	?
Due to:	
Other conditions: Benign hypertrophy of Prostate	?

(Include pregnancy within 3 months of death)

Major findings: Of operations: no operation

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Howard L. Tolson M.D. M. D. or other
Address Cumberland, Md Date signed 1-21-40

RECEIVED
FEB 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

0067

Reg. Dist. No. 8

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 69 - 3 - 21

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: East Main St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: John Peebles

3. (b) Social Security Number: 218-07-4627

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Mary A. Wiland

6(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Sept. 28, 1871

8. AGE:

Years	Months	Days	If less than one day
69	3	21	____ hrs. ____ min.

9. Birthplace: Lonaconing, Md
(Town, county, and state)

10. Usual occupation: Stationary Fireman

11. Industry or business: County Home

FATHER
12. Name: Thomas Peebles
13. Birthplace: Scotland

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Melvin Peebles
Address: Lonaconing, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 21, 40 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Lonaconing, Md

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md

19. Jan 21 1940 (Date rec'd by registrar) Dr. E. Don Taylor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 18 1940, at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 14 1940, to Jan 18 1940, and that I last saw h[illegible] alive on Jan 17 1940.

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Henry M. Hodgson M. D.
M. D. or other

Address: Lonaconing, Md Date signed: Jan. 20 40

RECEIVED
FEB 0 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

0068

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-R)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town LONG Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. B. STREET
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Boy Poling

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	INFANT

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 10, 1939

8. AGE: Years | Months I | Days 7 | If less than one day hrs. min.

9. Birthplace CUMBERLAND, MD, MEMORIAL HOSPITAL
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Wilson Poling
13. Birthplace West Virginia

MOTHER
14. Maiden name Juanita Corfield
15. Birthplace West Virginia

16. Informant WILSON POLING
Address LONG, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 28-39 (month) (day) (year)

Cemetery or crematory Rose Hill

Location Cumberland, Md.

18. Funeral director V. L. Lemperer

Address Cumberland, Md.

19. Jan. 23, 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

DR. J. K. COWHERD

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17, 1940, at 12:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 10/39 19 , to Jan. 17/39 19 , and that I last saw him alive on Jan 16/39 19 .

Immediate cause of death Open Foramen ovale - From birth

Due to

Due to

Other conditions Congenital Atelectasis
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. K. Cowherd M. D. Cumberland Md

Address ~~Jan 18~~ Date signed Jan. 18/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (51-E)

0069

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Ellerslie County: Allegany
City or town: Ellerslie Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME: John P. Porter

3. (b) Social Security Number

4. Sex: male
5. Color or race: white
6. (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Ella Robinette
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): March 6, 1869

8. AGE: Years 71 | Months 10 | Days 17 | If less than one day ____ hrs. ____ min.

9. Birthplace: Mt. Savage Md. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business
FATHER
12. Name: Stephan Porter
13. Birthplace: Md.
MOTHER
14. Maiden name: Elizabeth Hill
15. Birthplace: Virginia
16. Informant: J. S. Hutton
Address: Ridgeley West Va.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 26 40 (month) (day) (year)
Cemetery or crematory: Rose Hill
Location: Cumb. Md
16. Funeral director: Louis Stein Inc
Address: Cumberland Md.
19. Jan. 25, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 23 1940, at 8 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 8 1937, to Jan 23 1940, and that I last saw him alive on Jan 22 1940.

Immediate cause of death: Carcinoma of prostate — DURATION: about 2½ mo.
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings: Sept 15" 1937 prostate was removed suprapubically and found by laboratory to be malignant.
Of operations
Of autopsy: metastatic carcinoma of left ilium. Prostatic urethra closed entirely

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE: R. W. Trevaskis, M.D. M. D. or other
Address: Cumberland, Md Date signed: 1/24/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Myosin

RECEIVED
FEB 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

0070

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 620 Washington St

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 620 Washington St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Walter Powell

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary F Dart

— 6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): June 6 1851

8. AGE: Years 88 Months 7 Days 3 If less than one day ___ hrs. ___ min.

9. Birthplace: England (Town, county, and state)

10. Usual occupation: Retired Judge

11. Industry or business: Orphans Court

FATHER
12. Name: Mark Powell
13. Birthplace: England

MOTHER
14. Maiden name: Unknown
15. Birthplace: England

18. Informant: Virgil Powell

Address: Cumberland Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof Jan 11 1940 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem

Location: Cumberland Md

18. Funeral director: Louis Stein Inc

Address: Cumberland Md

19. Jan 11, 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan, 9, 1940, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 3, 1940, to Jan, 9, 1940, and that I last saw him alive on Jan 9, 1940.

Immediate cause of death: Debility of old age

Due to

Due to

Other conditions: Hypertrophied Prostate Arteriosclerosis.
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph P. Franklin M. D. or other

Address Cumberland Md. Date signed 1/11/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (87-2)

0071

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 130 Seymour St

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 130 Seymour St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Warren Logan Proudfoot

3. (b) Social Security Number

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Single.

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5 1921

8. AGE: Years 19 Months 0 Days 19 If less than one day hrs. min.

9. Birthplace Cumberland. Md.
(Town, county, and state)

10. Usual occupation Invalid for life.

11. Industry or business

FATHER
12. Name Otto Proudfoot
13. Birthplace West, Va.

MOTHER
14. Maiden name Bertha Coleman
15. Birthplace West Va.

16. Informant Mr Otto Proudfoot

Address Cumberland Md

17. Burial Date thereof Jan 26 40
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Cem.

Location Cumb. Md.

18. Funeral director Louis Stein Inc.

Address Cumberland, Md

19. Jan. 25, 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24, 1940, at 4 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1935, to Jan. 24, 1940, and that I last saw him alive on Jan. 23, 1940.

Immediate cause of death Lethargic Encephalitis Post-Encephalitis

DURATION Jan. 1929 Five years

Due to Does not require a report as an acute infectious disease, because condition developed

Due to in 1929, C.W.F.R.

Cause of death: Post-encephalitis, which grew progressively worse since 1929.

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clay E. Durrett
M. D. or other

Address Cumberland. Md Date signed Jan. 24, 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Durrett

I

(M)

(T)

RECEIVED
FEB 8 1940
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 134-C

Reg. Dist. No. 4

0072

CERTIFICATE OF DEATH

1. PLACE OF DEATH
(a) County Allegany
(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: R D 2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County Allegany
(c) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(d) Street No. R D 2 (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Amanda Elizabeth Ray

3 (b) If veteran, name war: no
3 (c) Social Security No. no

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife Franklin Ray
6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept 3 1861

8. AGE: Years 79 | Months 4 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Pa (Town, county, and state)
10. Usual occupation House Wife
11. Industry or business

FATHER
12. Name Henry Beatty
13. Birthplace Ireland

MOTHER
14. Maiden Name Delila Barney
15. Birthplace Pa

16 (a) Informant Edsie Ray
(b) Address Cumberland md RD 2

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 13 1940 (month) (day) (year)
(c) Cemetery or crematory Rook Valley Pa
Location Fulton Pa

18 (a) Funeral director Ephraim Smith
(b) Address Artemas Pa

19 (a) Jan 11 1940 (Date rec'd by registrar) (b) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death Jan 9 1940, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 22 1939, to Jan 9 1940, and that I last saw him alive on Jan 9 1940.

Immediate cause of death	Duration
(a) Endocarditis & Myocarditis	Several years
Due to (b)	
Due to (c)	
Other conditions Chronic Nephritis & Hypertension	

(Include pregnancy within 3 months of death)

Major findings:
Of operations (d)
Of autopsy (e)

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. L. Franich M.D. (M. D. or other)
Address Cumberland Md. Date signed 1/10 - 40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

0073

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (125)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 534 Princeton St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 7 mos 3 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 534 Princeton St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Ray Roger Reed

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 10 1939

8. AGE: Years | Months 7 | Days 3 | If less than one day hrs. min.

9. Birthplace Cumberland Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name John Reed

13. Birthplace Md.

MOTHER 14. Maiden name Geraldine Pepper

15. Birthplace W. Va.

16. Informant John Reed

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-16-40 (month) (day) (year)

Cemetery or crematory Greenmount Cem.

Location Cumberland

18. Funeral director Louis Stein Inc.

Address Cumberland

19. Jan. 16 1940 J. P. Franklin, M.D. (Date rec'd by registrar) Registrar

Johnson

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13 1940, at 2 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 6 1940, to January 13 1940, and that I last saw h[illegible] alive on January 13 1940.

Immediate cause of death Hypertrophy of Liver — DURATION 1 week

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy Hypertrophy of Liver & Spleen

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James T. Johnson M. D. or other

Address Cumberland Md. Date signed 1-13-40

RECEIVED
FEB 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

0074

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 101 Decatur St.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 77 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 101 Decatur St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Margaret Reith

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: August Reith
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 15 1867

8. AGE:

Years	Months	Days	If less than one day
72	7	11	hrs. min.

9. Birthplace: Cumberland, Allegany Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business

FATHER
12. Name: Henry Schlunt
13. Birthplace: Germany

MOTHER
14. Maiden name: Katherine Rohrbach
15. Birthplace: Germany.

16. Informant: John Schlunt
Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-28-40 (month) (day) (year)
Cemetery or crematory: Trinity Lutheran Cem.
Location: Cumberland.

18. Funeral director: Louis Stein Jose.
Address: Cumberland.

19. Jan. 28, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 26 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-26-40 19, to 1-26-40 19, and that I last saw h alive on 1-26-40 19

Immediate cause of death	DURATION
Apoplexy	
Due to: Hypertension	2 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: C. C. Emmert M. D. or other
Address: Cumberland Md. Date signed: 1-27-40

RECEIVED
FEB 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

0075

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 716 Oldtown Road

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 71 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 716 Oldtown Road
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Cora Jeanette Rice

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife: William H. Rice

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 18, 1868

8. AGE: Years: 71 Months: 4 Days: 28 If less than one day: hrs. min.

9. Birthplace: Cumberland, Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Samuel Holdus
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Amanda McGinnis
15. Birthplace: Indianapolis Indiana.

16. Informant: Edna Lapp
Address: 716 Oldtown Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 19, 1940 (month) (day) (year)

Cemetery or crematory: Emmanuel Cemetery

Location: Cumberland, Md

18. Funeral director: Jacob Hofer

Address: 730 Baltimore St.

19. 1-19-40 (Date rec'd by registrar) Jos. P. Franklin, M.D. Registrar

L. J. Lanich

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 16. 1940, at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 13. 1938, to Jan. 16. 1940, and that I last saw her alive on Jan. 16. 1940

Immediate cause of death	DURATION
Cirrhosis of liver & pneumonia	2 yrs.
Due to	
Due to	
Other conditions: Diabetus Mellitus	10 yrs.

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: no.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of:

Where did Injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L. J. Lanich. M.D.
M. D. or other

Address: 108 Va. Ave. Cumberland, Md. Date signed: 1/18/40

RECEIVED
FEB 8 1940
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (112)

CERTIFICATE OF DEATH

0076

Reg. Dist. No. 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:

County Allegany

City or town Barrellville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 4 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Rural Near Mt Savage Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Barrellville near Mt Savage
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Stanley Ronald Ricewick.

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single.

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 17 - 1939

8. AGE: Years | Months 4 | Days 26 | If less than one day hrs. min.

9. Birthplace Barrellville Allegany Md.
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name Daniel A. Ricewick.
13. Birthplace Mt Savage Md.

MOTHER
14. Maiden name Mary Viola Kniseum.
15. Birthplace Mt Savage Md

16. Informant Daniel Ricewick.
Address Mt Savage Md

17. Burial Date thereof Jan 14. 1940.
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Methodist

Location Mt Savage Md.

18. Funeral director E. Durst.
Address Frostburg Md.

19. 1-13 1940 H. F. Bostetter M.D.
(Date rec'd by registrar) Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13 1940, at 5A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 11 1940, to Jan 13 1940.

and that I last saw him alive on Jan 11 1940.

Immediate cause of death	DURATION
Spasmodic Bronchial asthma	2 wks.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. F. Bostetter M. D.
M. D. or other

Address Mt Savage Md Date signed 1-13-40

RECEIVED
FEB 2 1948
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (49-C)

CERTIFICATE OF DEATH

0077

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 540 Greene St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 540 Greene St

(If rural give LOCATION)

2(e) IF VETERAN, NAME WAR

3. (a) FULL NAME Elizabeth Ritchey

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife James Ritchey

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Mar 19 1864

8. AGE: Years	Months	Days	If less than one day
75	9	50	____ hrs. ____ min.

9. Birthplace Meyersdale Pa (Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

FATHER 12. Name David Evans

13. Birthplace Pa

MOTHER 14. Maiden name Priscilla Lingg

15. Birthplace Pa

16. Informant Wm M. Ritchie

Address Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 11 1940 (month) (day) (year)

Cemetery or crematory Trinity Little Cem

Location Cumberland Md

18. Funeral director Louis Stein Sons

Address Cumberland Md

19. Jan 11 19 40 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9, 1940, at 10:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-19-39 19 , to 1-9-40 19 ,

and that I last saw here alive on 1-9-40 19

Immediate cause of death	DURATION
(a) Pneumonia Vagus	2
Due to (b)	
Due to (c)	
Other conditions Arteriosclerosis	2

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. C. Zimmerman M.D. M. D. or other

Address Cumberland Md Date signed 1-10-40

RECEIVED
FEB 6 1940
BUREAU

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52-6)

0078

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 105 Oak St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 105 Oak St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: World War

3. (a) FULL NAME: Vincent Everette Roberts

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Divorced

6 (b) Name of husband or wife: Unknown

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Nov. 19, 1890

8. AGE:

Years	Months	Days	If less than one day
49	2	11	____ hrs. ____ min.

9. Birthplace: Flintstone, Md.
(Town, county, and state)

10. Usual occupation: Car Man Hadn't worked since 1924

11. Industry or business: B.&O. Railway Co.

FATHER
12. Name: Francis L. Roberts
13. Birthplace: Penna.

MOTHER
14. Maiden name: Mary Alice Bennett
15. Birthplace: Penna.

16. Informant: Mrs. Grace Nicholson
Address: 310 Penna. Ave. Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 1, 1940 (month) (day) (year)

Cemetery or crematory: Hillcrest Cem.

Location: Cumberland.

18. Funeral director: J. C. Wolford

Address: Cumberland, Md.

19. Feb. 1, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 29, 1940, at 11P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 1940, to Jan 29 1940, and that I last saw h____ alive on ____ 19____.

Immediate cause of death: Secondary Anaemia

Due to: Carcinoma of bladder

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION: about 1 yr

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: 133 Va[illegible] Date signed: Jan 31 '40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

I

(M)

(T)

RECEIVED
FEB 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-R)

0079

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) 29 days

Stay in this community (yrs., or mos., or days) 40 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State 528 BROADWAY CIRCLE, County

City or town CUMBERLAND MD. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME RODENHAUSER, GEORGE

3. (b) Social Security Number 352 220-10-0148

4. Sex: MALE

5. Color or race: WHITE

6. (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife SIGLER, BLANCHE

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Oct. 30, 1871

8. AGE: Years 68 | Months 2 | Days 4 | If less than one day ___ hrs. ___ min.

9. Birthplace MD. (Town, county, and state)

10. Usual occupation MACHINIST (FURLOUGHED)

11. Industry or business

FATHER
12. Name RODENHAUSER, JOHN
13. Birthplace GERMANY

MOTHER
14. Maiden name NICKEL, ANNA
15. Birthplace GERMANY

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 6, 1939 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Maryland

18. Funeral director Louis Stein, Inc.

Address Cumberland, Maryland

19. Jan. 5 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. HODGES

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 3, 1940 19 4:50 P.M. at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 5 1939 to Jan 3 1940 and that I last saw him alive on Dec. 3 1940.

Immediate cause of death: Retroperitoneal neoplasms malignant. C.W.G.R.

Due to Primary site: Retroperitoneal glands. Duration: two years.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations Large mass pushing forward into lower abdomen.

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury — Injured at work?

23. SIGNATURE W. R. Hodges, M.D. M. D. or other

Address Cumberland, Md. Date signed 1/8/40.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M) (T) I

RECEIVED
FEB 6 1940

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0080

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 235 Glenn St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 50 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 235 Glenn St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Clairbell Shuck Rohrer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6 (b) Name of husband or wife Wm D. Rohrer

6(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) June 23, 1871

8. AGE: Years	Months	Days	If less than one day
68	6	9	hrs. min.

9. Birthplace Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation House work

11. Industry or business At Home.

FATHER 12. Name George E. Shuck

13. Birthplace Cumberland Md.

MOTHER 14. Maiden name Mary Marks

15. Birthplace Cumberland Md

16. Informant Miss Jeanette Rohrer

Address 235 Glenn St. Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 5 (month) (day) 1940 (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director Jacob Hofer

Address Cumberland, Md.

19. Jan. 3 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1940, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15 1939, to Jan 2 1940, and that I last saw h er alive on Dec 29 1939.

Immediate cause of death	DURATION
Chronic Myocarditis	3 yrs.
Due to Arterial hypertension	5 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. H. Trevaskis, M.D.
M. D. or other

Address Cumberland Md Date signed Jan 3-40

RECEIVED
FEB 6 1940
BUREAU V. S.

0081

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 7

1. PLACE OF DEATH:

County Allegany

City or town Dan's Mt. near Barton Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 50 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Amanda Ross

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

B (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 1860

8. AGE: Years	Months	Days	If less than one day
79	8		hrs. min.

9. Birthplace Oldtown - Md.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Own Home

FATHER
12. Name Henry Ross
13. Birthplace Barton, Md.

MOTHER
14. Maiden name Lucinda Duckworth
15. Birthplace Not Known

16. Informant Lee Ross

Address Dan's Mt. near Barton

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 1940 (month) (day) (year)

Cemetery or crematory ~~Hilton~~ Llewellyn

Location 3 mi E of Westernport, Md

18. Funeral director D. S. Boal

Address Westernport, Md

19. Jan 3 1940 (Date rec'd by registrar) S. A. Boucher Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1 1940, at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,

and that I last saw h alive on 19

Immediate cause of death Chronic Myocarditis DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Linna H. Corson, M.D.
M. D. or other

Address Cumberland, Md. Date signed 1/1/40

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52-2)

CERTIFICATE OF DEATH

0082

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city of town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 315 Cedar St

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 55 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland, Md. Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 315 Cedar St (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: George P. Schaidt

3. (b) Social Security Number: 300-214-05-9063

4. Sex: M

5. Color or race: W

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nellie B Schaidt

6(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): Apr. 18, 1879

8. AGE: Years: 60 | Months: 8 | Days: 22 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Berlin Germany (Town, county, and state)

10. Usual occupation: Rougher

11. Industry or business: Tin Plate Mill

FATHER 12. Name: Conrad Schaidt

FATHER 13. Birthplace: Berlin Germany

MOTHER 14. Maiden name: Mary Lutting

MOTHER 15. Birthplace: Berlin Germany

16. Informant: Mrs. Cora H. Furman

Address: Bowling Green, Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 13, 1940 (month) (day) (year)

Cemetery or crematory: Greenmount

Location: Cumberland

18. Funeral director: Jacob Lofer

Address: Cumberland

19. Jan. 11, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 10, 1940, 7A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 7, 1939, to Jan 10, 1940, and that I last saw h[illegible] alive on Dec 21, 1939

Immediate cause of death: Cancer of bladder — DURATION: 1 year

Due to:

Due to:

Other conditions: Pyonephritis (Left kidney) — 1 month

(Include pregnancy within 3 months of death)

Major findings:

Ot operations:

Ot autopsy: Same as above.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: P. P. Trevorakis M.D. M. D. or other

Address: Cumberland, Md. Date signed: 1/11/40

RECEIVED
FEB 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0083

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH.

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 30 Green St

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 30 Green St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME Michael Schoonkay

3. (b) Social Security Number 705-12-0880

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife: Anna Kelley

6(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): August 24 - 1872

8. AGE: Years	Months	Days	If less than one day
67	4	20	____ hrs. ____ min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Machinist - Retired

11. Industry or business: B & O R.R. Co

FATHER
12. Name: Martin Schoonkay
13. Birthplace: Germany

MOTHER
14. Maiden name: Mary Smith Kilroy
15. Birthplace: Germany

16. Informant: Martin Schoonkay
Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 18-40 (month) (day) (year)

Cemetery or crematory: St Peter & Paul Cem

Location: Cumberland, Md.

18. Funeral director: V. L. Lemperenes

Address: Cumberland Md

19. Jan. 19, 1940 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 14 1940, at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 12 1940, to Jan 14 1940, and that I last saw h— alive on Jan 14 1940

Immediate cause of death: Septicemia

DURATION: 5 days

Due to: —

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings:

Of operations: —

Of autopsy: —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: J. H. Sprigg M. D. or other

Address: Cumberland, Md. Date signed —

RECEIVED
FEB 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

0084

CERTIFICATE OF DEATH

Reg. Dist. No. 4a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 44 South St.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 50 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 44 South
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Bertha Julia Schultz.

3. (b) Social Security Number: None

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Frank Schultz
6(c) If alive, give age: [illegible] years
7. Birth date of deceased (mo., day, yr.): Feb. 10 1867
8. AGE: Years: 72 Months: 11 Days: 21 If less than one day: hrs. min.
9. Birthplace: Germany (town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Joseph Kalbermann
13. Birthplace: Germany.
MOTHER 14. Maiden name: Unknown.
15. Birthplace:
16. Informant: John A. Schultz. Address: Cumberland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 3 40 (month) (day) (year)
Cemetery or crematory: St. Peter & Paul Cem
Location: Cumberland, Md.
18. Funeral director: Louis Steinhauer
Address: Cumberland Md
19. Feb. 2 1940 (Date rec'd by registrar) Jos. P. Franklin MD. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 31 19 40, at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 28 19 40, to Jan 31 19 40, and that I last saw h[illegible] alive on Jan 01 19 40.

	DURATION
Immediate cause of death: Lobar Pneumonia	4 da.
Due to: Type III	
Due to:	
Other conditions: Diabetes Insipidus	several yrs
Chronic Nephritis & Hypertension	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: C. J. Kanich MD. M. D. or other
Address: Cumberland Md Date signed: 2/1/40

RECEIVED
FEB 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 157-C

Reg. Dist. No. 9

0085

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Frostburg (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: 73 Armstrong St.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) —

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Allegany

(c) City or town Grahamtown (If outside city or town limits, write RURAL and give town)

(d) Street No. 73 Armstrong St (If rural give location)

(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Scott

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 30, 1939

8. AGE: Years | Months | Days 2 | If less than one day hr. min.

9. Birthplace Near Frostburg (Town, county, and state)

10. Usual occupation 0

11. Industry or business 0

FATHER

12. Name Geo. E. Scott

13. Birthplace Vale Summit Md.

MOTHER

14. Maiden Name Pauline Williams

15. Birthplace Frostburg Md.

16 (a) Informant Geo. Scott

(b) Address Frostburg Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof Jan. 1-1940 (month) (day) (year)

(c) Cemetery or crematory Methodist Cem.

Location Vale Summit Md

18 (a) Funeral director George E. Scott

(b) Address Grahamtown Md

19 (a) Jan. 1-1940 (Date rec'd by registrar) (b) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death 1-1-40 19__, at 8 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 30 1939, to Jan 1 1940, and that I last saw him alive on Dec 31 1939.

Immediate cause of death Found dead in bed

Due to Probably a patient for [illegible]

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. C. Cohen M. D. or other

Address Frostburg Date signed 1-1-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 9 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55P)

CERTIFICATE OF DEATH

0086

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) 130 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. MAPLESIDE
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME JOHN SEIBERT

3. (b) Social Security Number 163 219-03-8811

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEBRUARY 1 1870.

8. AGE:

Years	Months	Days	If less than one day
69	11	15	hrs. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation UNEMPLOYED

11. Industry or business

FATHER 12. Name WILLIAM SEIBERT

13. Birthplace unknown

MOTHER 14. Maiden name SARAH FAZENBAKER

15. Birthplace MARYLAND

16. Informant Wm. Sommerville, Atty.

Address Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 19, 1940 (month) (day) (year)

Cemetery or crematory Family Cemetery

Location Near Bittner, Md.

18. Funeral director Louis Stein, Inc.

Address Cumberland, Maryland

19. Jan. 17 (Date rec'd by registrar) 19 40 J. P. Franklin, M.D. Registrar

C. Bowen

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 16 19 40, at 7:20 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 8 19 39, to Jan 16 19 40, and that I last saw h alive on Jan 15 19 40.

Immediate cause of death Hypostatic Pneumonia — DURATION 5 Days

Due to Malignancy Multiple areas involving

Due to site of Rectum, ?

Primary ? Secondary Duration - Six months

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. C. Bowen M.D. M. D. or other

Address Cumberland, Md. Date signed 1-16-40

RECEIVED
FEB 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00879

Reg. Dist. No. 1

1. PLACE OF DEATH:
County: Allegany
City or town: Eckhart Mines
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Eckhart Mines Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Albert Lee Shanholtz
3. (b) Social Security Number: None 543 No record A00

4. Sex: M
5. Color or race: W
6. (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Annie M. Shanholtz
6(c) If alive, give age: 64 years
7. Birth date of deceased (mo., day, yr.): Nov 7 — 1875
8. AGE: Years 64 Months 2 Days 15 If less than one day ___ hrs. ___ min.
9. Birthplace: Levels W. Va (Town, county, and state)
10. Usual occupation: Religious work
11. Industry or business: bibel salesman
FATHER 12. Name: Taylor Shanholtz
13. Birthplace: unknown
MOTHER 14. Maiden name: Lucinda Haines
15. Birthplace: W. Va.
16. Informant: Mrs Annie Shanholtz
Address: Eckhart, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 25 - 1940 (month) (day) (year)
Cemetery ~~or crematory~~: Eckhart
Location: Eckhart Md.
18. Funeral director: J. J. Durst
Address: Frostburg Md
19. 1 - 25 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 22 1940, at 7:00 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 1940, to Jan 22 1940, and that I last saw him alive on Jan 22 1940.

	DURATION
Immediate cause of death: Broncho-Pneumonia	1 Day
Due to: Chronic Bronchitis	? ?
Due to: Chronic myocarditis	? ?
Other conditions: & Hypertension	? ?

(Include pregnancy within 8 months of death)
Major findings:
Of operations: —
Of autopsy: —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. O. McLane Jr. M.D. M. D. or other
Address: Frostburg Md Date signed: Jan 23 '40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0088

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 834 N. Mechanic St.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 20 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 834 N. Mechanic St.
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Lula Myrtle Shriver

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: George Frederick Shriver
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 2, 1889

8. AGE: Years	Months	Days	If less than one day
50	8	12	hrs. min.

9. Birthplace: Eckart, Allegany, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At home
FATHER 12. Name: Conrad Rephan
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Catherine Lancaster
MOTHER 15. Birthplace: Maryland
16. Informant: Cecil Shriver
Address: Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof January 17, 1940 (month) (day) (year)
Cemetery or crematory: Eckart Cemetery
Location: Eckart, Maryland
18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland
19. Jan. 17, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

Pankman

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 14, 1940, at 6 4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1, 1940, to Jan 14, 1940, and that I last saw ~~her~~ alive on Jan 13, 1940.

Immediate cause of death	DURATION
Lobar Pneumonia	6 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: ✓
Of autopsy: ✓

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Geo P Faulkman M. D. or other
Address: 142 S Liberty St Date signed: Jan 15 1940

JAN 24 1940
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-)

CERTIFICATE OF DEATH

0089

Reg. Dist. No. 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Mt Savage, Rural near. (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 53 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Mt Savage Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Charles Henry Smith.

3. (b) Social Security Number: None 220-10-2342

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife: Jennie Myrtle Smith.

6(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): Sept 13, 1886

8. AGE:

Years	Months	Days	If less than one day
53	4	3	hrs. min.

9. Birthplace: Mt Savage Allegany Md. (Town, county, and state)

10. Usual occupation: Brick Worker

11. Industry or business: Fire Brick Plant

FATHER 12. Name: Charles Smith

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Mary Lynch

MOTHER 15. Birthplace: Mt Savage Md.

16. Informant: Mrs. Violet Stull

Address: Cresaptown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 20 1940 (month) (day) (year)

Cemetery or crematory: St Patrick's Cemetery

Location: Mt Savage Md.

18. Funeral director: Jacob Hafer

Address: Frostburg Md.

19. Jan 18 1940 (Date rec'd by registrar) H. J. Bostetter M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 16 1940, at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 25 1939, to Jan 16 1940 and that I last saw him alive on Nov 30 1939

Immediate cause of death	DURATION
Auricular Fibrilation	6 mo.
Due to Chronic Nephritis	1 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. J. Bostetter M.D. M. D. or other

Address: Mt Savage Md. Date signed: 1-18-40

RECEIVED
FEB 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-d)

0090

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND MARYLAND
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hosp

Stay in hospital or inst. (yrs., or mos., or days) 6 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. BALTIMORE PIKE
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME MR. WILLIAM H. SMOUSE

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6 (b) Name of husband or wife Late Annie M. Carleton

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) DEC. 6, 1858

8. AGE:

Years	Months	Days	If less than one day
81	1	6	____ hrs. ____ min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name PETER SMOUSE
13. Birthplace Md

MOTHER
14. Maiden name Elizabeth Neff
15. Birthplace Md

16. Informant Bender Smouse
Address Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 13/40 (month) (day) (year)

Cemetery or crematory Rose Hill

Location Cumberland Md

18. Funeral director V. L. Lemperen
Address Cumberland, Md.

19. Jan. 13 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

DR. HAWKINS

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 12, 1940 19 ____, at 12;30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 8 1940 to Jan 12 1940 and that I last saw him alive on Jan 11 1940

Immediate cause of death Carcinomatosis

Due to Carcinoma of face on right cheek

Due to Involving maxilla

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. E. Aspell M. D. or other

Address Cumberland Date signed 1/12/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

0091

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-E)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 504 Averitt Place

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 504 Averitt Place
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Rose Mary Sochner

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 17, 1922

8. AGE: Years 17 Months 5 Days 14 If less than one day hrs. min.

9. Birthplace Cumberland, Md
(Town, county, and state)

10. Usual occupation Student

11. Industry or business

FATHER
12. Name Elmer Sochner
13. Birthplace Dayton Ohio

MOTHER
14. Maiden name Rose Westendorf
15. Birthplace Dayton Ohio

16. Informant Elmer Sochner

Address 504 Averitt Place

17. Burial Date thereof Feb 3 1940
(Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory Dayton Cem.

Location Dayton Ohio.

18. Funeral director Louis Stein Inc

Address Cumberland Md

19. Feb. 2 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31st 1940, at 8 20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 2 1939, to Jan 31 1940, and that I last saw her alive on Jan 31 1940.

Immediate cause of death Melastatic Sarcoma Lungs

Due to Primary Sarcoma

Due to Left Knee

Other conditions Secondary Anemia

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy None

DURATION 6 Mos

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J H Matthews M. D. or other

Address 101 So Centre St Date signed 2/1/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 6 1940
BUREAU U. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

WITHIN CORPORATE LIMITS

0092 9

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Miners Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Frostburg Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 175 Bowery (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Jennie M Sonnenburg

3. (b) Social Security Number: None

4. Sex: F

5. Color or race: W

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Charles F. Sonneburg

6(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): Feb. 8 - 1854

8. AGE: Years 75 Months 11 Days 23 If less than one day ___ hrs. ___ min.

9. Birthplace: Glostershire Wales (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER 12. Name: David Owens

13. Birthplace: Wales

MOTHER 14. Maiden name: Mary Thomas

15. Birthplace: Wales

16. Informant: Charles F. Sonneburg

Address: Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 3-1940 (month) (day) (year)

Cemetery or ~~crematory~~: allegany

Location: Frostburg

18. Funeral director: J. J. Durst

Address: Frostburg

19. Feb. 3rd 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 31 1940, at 6:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1939, to Jan 31 1940, and that I last saw her alive on Jan 31 1940.

Immediate cause of death: Carcinoma of Stomach — DURATION: 7 / 1

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations: None

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. O. McLane Jr. MD M. D. or other

Address: Frostburg Md Date signed: Feb 2 1940

RECEIVED
MAR 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

0093 9

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 81 W. Main St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days): 57-11-15

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 81 W. Main St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Rebecca Bertha Stern

3. (b) Social Security Number:

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Feb 22, 1881

8. AGE: Years: 57 | Months: 11 | Days: 15 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Frostburg, Allegany, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Bernard Stern
13. Birthplace: Hungary

MOTHER
14. Maiden name: Ida Hershberger
15. Birthplace: Berlin - Germany

16. Informant: George Stern
Address: Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 9, 1940 (month) (day) (year)
Cemetery or crematory: East View Cemetary
Location: Cumberland.

18. Funeral director: Jacob Hafer.
Address: Frostburg, Md.

19. Jan. 9 1940 (Date rec'd by registrar) Mrs. L. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 7 19 40, at 12 00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1936 to Jan 7 19 40, and that I last saw her alive on Jan 7 19 40.

Immediate cause of death: Carcinoma of Breast — DURATION: 4 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations: Carcinoma of Left Breast
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Wm Stone Jr. M. D. or other
Address: Frostburg Md — Date signed Jan 8 1940

RECEIVED
FEB 3 1940
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (180)

Reg. Dist. No. 4

CERTIFICATE OF DEATH

0094

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: R F D # 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 57 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Allegany
(c) City or town Cumberland, (If outside city or town limits, write RURAL and give town)
(d) Street No. R F D # 3 (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Elmer Wilson Strong

3 (b) If veteran, name war

3 (c) Social Security No. 220-03-7369

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife ____

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 3-15-1882

8. AGE: Years 57 | Months 10 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace Cumberland (Town, county, and state)

10. Usual occupation Construction Laborer

11. Industry or business W. P. A.

FATHER
12. Name David Strong
13. Birthplace Cumberland

MOTHER
14. Maiden Name Mary Lafferty
15. Birthplace Cumberland

16 (a) Informant Joseph M Strong
(b) Address Cumberland Md RFD #2 Box 163

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-40 (month) (day) (year)
(c) Cemetery or crematory Rose Hill Cemetery
Location Cumberland, Md

18 (a) Funeral director Wm. H. Knight
(b) Address Cumberland Md

19 (a) Jan. 31, 1940 (Date rec'd by registrar) (b) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death January 30th., 1940, at about 12.15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____, and that I last saw him alive on ____ 19____.

Immediate cause of death	Duration
Burning, head, neck and trunk, charred, legs and arms destroyed.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations ____
Of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident.
(b) Date of occurrence January 30th., 1940
(c) Where did injury occur? Near Cumberland, (City or town) Allegany (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury burning of his home

23. Signature Edward H. Beall M.D. (M. D. or other)
Address Cumberland, Md. Date signed 1-30-40

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

0095

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital.

Stay in hospital or inst. (yrs., or mos., or days) 1 week

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State W. Va County Mineral

City or town Rural Ridgeley Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Frankfort Road.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME Laura Frances Lewis Swick

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Kenny Swick

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.): Feb 12, 1875

8. AGE: Years 64 Months 11 Days 5 If less than one day ___ hrs. ___ min.

9. Birthplace: Oakland, Garrett Co, Md.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: At Home

FATHER
12. Name: Wm Lewis
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Mrs May Hammond.
Address: 23 Lamont St - Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 19 1940. (month) (day) (year)

Cemetery or crematory: Old Hampshire Cemetery

Location: Cumberland, Md

18. Funeral director: Jacob Hafer

Address: Cumberland, Md

19. 1-19-40 (Date rec'd by registrar) Jos. P. Franklin, M.D. Registrar

Dr. Lauch

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17 1940, at 5:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 12 1940, to January 17 1940, and that I last saw her alive on January 17 1940.

Immediate cause of death: Chronic Myocarditis — DURATION: 2 years

Due to

Due to: Chronic Cholecystitis — 3 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: E. V. Bro. Mfg. M.D.
M. D. or other

Address: Cumberland, Md Date signed 1/18/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (2) Reg. Dist. No. 8

CERTIFICATE OF DEATH

0096

1. PLACE OF DEATH
(a) County Allegany
(b) City or town Midland (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital or institution: Miller Road
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 0

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County
(c) City or town Stillborn (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** Baby boy Thrasher

3 (b) If veteran, name war —
3 (c) Social Security No. —

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife
6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16. 1940

8. **AGE:** Years | Months | Days | If less than one day
Stillborn | hr. | min.

9. Birthplace Midland, Md. (Town, county, and state)

10. Usual occupation
11. Industry or business

FATHER
12. Name William A. Thrasher
13. Birthplace Midland, Md.

MOTHER
14. Maiden Name Ruth Elizabeth Copley
15. Birthplace Locust Grove, Md.

16 (a) Informant
(b) Address

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 1 16 1940 (month) (day) (year)
(c) Cemetery or crematory Furnace
Location Keene

18 (a) Funeral director
(b) Address

19 (a) 1-16-40 (Date rec'd by registrar) (b) E. Dan Taylor Registrar

MEDICAL CERTIFICATION

20. Date of death Jan 16 1940, at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw him alive on 19.

Immediate cause of death	Duration
Stillborn	
Due to	
Due to (Mother's Fall)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. M. Shelton Jr. M.D. (M. D. or other)
Address Midland, Md. Date signed 1-16-40

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
FEB 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

0097

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany 2

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days): 40 minutes

Stay in this community (yrs., or mos., or days): 40 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Alleg.

City or town: Frank. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(o) IF VETERAN, NAME WAR

3. (a) FULL NAME: Baby Boy Thrasher

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Jan. 5, 1940

8. AGE: Years | Months | Days | If less than one day: ____ hrs. 40 min.

9. Birthplace: Cumberland, Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Wilbur Elmer Thrasher

FATHER 13. Birthplace: Cumberland, Maryland

MOTHER 14. Maiden name: Mildred Marie Ansil

MOTHER 15. Birthplace: Lead Mine, W. Va.

16. Informant: Mrs. Mildred Thrasher

Address: 237 So. Water Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 5 1940 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland.

18. Funeral director: Father

Address: 237 S. Water St. Cumberland Md.

19. Jan 5 1940 (Date rec'd by registrar) Jos. F. Franklin Reg. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 5 1940, at 1:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 5 1940, to Jan 5 1940, and that I last saw h[illegible] alive on Jan 5 1940.

Immediate cause of death	DURATION
Prematurity (5 months gestation)	
Due to Twin pregnancy	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Anthony F. Jones M. D. (M. D. or other)

Address: 40 N. Liberty St. Date signed 1-5-40

RECEIVED
FEB 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

0098

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1 hour, 45 minutes

Stay in this community (yrs., or mos., or days): 1 hour, 45 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 237 So. Water St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Baby Girl Thrasher

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Jan 5, 1940

8. AGE: Years | Months | Days | If less than one day: 1 hrs. 45 min.

9. Birthplace: Cumberland Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Wilbur Elmer Thrasher
13. Birthplace: Cumberland Maryland

MOTHER
14. Maiden name: Mildred Marie Auvil
15. Birthplace: Lead Mine W. Va.

16. Informant: Mrs. Mildred Thrasher

Address: 237 S. Water Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 5, 1940 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland

18. Funeral director: Father

Address: 237 S. Water St. Cumberland Md

19. Jan 5 1940 (Date rec'd by registrar) Jos. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 5, 1940, at 2:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 5 1940, to Jan 5 1940, and that I last saw her alive on Jan 5 1940.

Immediate cause of death: Prematurity (5 months gestation)

Due to: Twin pregnancy

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Arthur F. Jones M.D.
M. D. or other

Address: 40 N. Liberty St. Date signed: 1-5-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1392)

0099

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 20 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 316 Maryland Ave
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Nora E. Trontman

3. (b) Social Security Number 214-10-4090

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 18 1897

8. AGE: Years 42 | Months 4 | Days 4 | If less than one day hrs. min.

9. Birthplace Flintstone Md.
(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business Dept. Store

FATHER
12. Name Charles E. Trontman
13. Birthplace Md.

MOTHER
14. Maiden name Rose May McCoy
15. Birthplace Md.

16. Informant Mrs Pritchard Carr

Address 5202 Ivanhoe Ave Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-24-40 (month) (day) (year)

Cemetery or crematory Greenmont Cem.

Location Cumberland Md.

18. Funeral director Louis Stein Inc.

Address Cumberland

19. Jan. 24, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-22-40 19 , at 1 40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 1940, to Jan 22 1940, and that I last saw her alive on Jan 22 1940.

Immediate cause of death: Intestinal Obstruction Peritonitis

Due to: The uterine tumor was benign.

Due to: Duration six years. O.W.G.R.

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations Jan 15th op. Leg Uterine tumor & Marian Gut.

Of autopsy None

DURATION: 5 days

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Matthews M. D. or other

Address 101 So Center St Date signed 1/23/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

RECEIVED
FEB 8 1940
BUREAU F. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0100

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 936 Gay St.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 936 Gay St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Ann Elizabeth Turner

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	White	Infant

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 30, 1938

8. AGE:

Years	Months	Days	If less than one day
1	6	14	hrs. min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Earl Rogan

FATHER — 13. Birthplace: Cumberland, Md.

MOTHER — 14. Maiden name: Kathleen Turner

MOTHER — 15. Birthplace: Morgantown, W. Va.

16. Informant: John Turner

Address: 936 Gay St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 17, 1940 (month) (day) (year)

Cemetery or crematory: Mt. Herman Cemetery

Location: Williams Road Cumberland

18. Funeral director: John C. Wolford

Address: Cumberland, Md.

19. Jan. 16, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 14, 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 13 1940, to Jan 14 1940, and that I last saw h alive on Jan 14 1940.

Immediate cause of death	DURATION
Pneumonia	1 wk
Due to Bronchitis	
Due to Pneumonia	5 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): No

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: 133 Va Ave Date signed: 1/14/40

RECEIVED
FEB 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

0101

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: MEMORIAL HOSPITAL
Stay in hospital or insf. (yrs., or mos., or days) 10 days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State W.VA. County HARDY
City or town OLDFIELDS Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME VAN METER, JAMES E.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife HOFFMAN, HILDA
6(c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) February 4 1885

8. AGE: Years	Months	Days	If less than one day
54	10	27	____ hrs. ____ min.

9. Birthplace W.VA. (Town, county, and state)
10. Usual occupation FARMER
11. Industry or business
FATHER 12. Name VAN METTER, ISAAC
13. Birthplace W.VA.
MOTHER 14. Maiden name PIER, MARTHA
15. Birthplace PENNA.
16. Informant MEMORIAL HOSPITAL
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 3 1940 (month) (day) (year)
Cemetery or crematory Van Meter Cemetary
Location Old Fields, W.Va.
18. Funeral director J. Thrush's
Address Moorefield, W.Va.
19. Jan. 2 1940 (Date rec'd by registrar) J.P. Franklin, M.D. Registrar

DR. W.F. WILLIAMS

MEDICAL CERTIFICATION 6:20 A M

20. DATE OF DEATH JAN. 1, 1940, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-22- 1939, to 1-1- 1940, and that I last saw him alive on 12-31- 1939.

Immediate cause of death	DURATION
Diabetes Mellitus	
Due to Diabetic Gangrene left foot & leg.	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wm. F. Williams M. D. or other
Address Cumberland Date signed 1-1-40

RECEIVED
FEB 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-9

0102

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 215 Carroll St

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 5 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)

State: Md County: Allegany.

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 215 Carroll St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Walter Scott Viney

3. (b) Social Security Number: 219-07-4490

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed.

6 (b) Name of husband or wife: Carrie Riley.

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 16 1879

8. AGE:

Years	Months	Days	If less than one day
60	0	20	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: General Farming.

FATHER
12. Name: James Viney
13. Birthplace: England

MOTHER
14. Maiden name: Sarah Fowler
15. Birthplace: Baltimore, Md.

16. Informant: Mrs Mildred Cauley
Address: 215 Carrol St - Cumberland

17. Burial — Date thereof Jan 9, 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Melchimes

Location: Pike Township Ohio

18. Funeral director: Jacob Hafer.

Address: Cumberland, Md

19. Jan. 6, 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

Dr Wallis

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 6, 1940, at 4:55 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10th 1939, to Jan 6 1940, and that I last saw h[im] alive on Jan 6 1940.

Immediate cause of death	DURATION
(a) Uremia,	
Cardio Renal Failure	
Due to (b) Mitral stenosis	
Due to (c) Syphilis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: J. H. Matthias M. D. or other

Address: 101 N. Centre St. Date signed

RECEIVED
FEB 8 1946
BUREAU V. S.

WITHIN CORPORATE LIMITS

0103

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (184)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 121 Baltimore St.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 45 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 249 Columbia St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Frederick William Vogel.

3. (b) Social Security Number: 220-10-9362

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Spence

6(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): Sept 17 1894

8. AGE: Years: 46 Months: 3 Days: 24 If less than one day: hrs. min.

9. Birthplace: Cumberland, Allegany Co, Md. (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Shoes

FATHER 12. Name: Henry Vogel

13. Birthplace: Germany.

MOTHER 14. Maiden name: Anna Flurschutz

15. Birthplace: Md.

16. Informant: John Beggs.

Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 15 40 (month) (day) (year)

Cemetery or crematory: Hillcrest Cem.

Location: Cumberland. Md

18. Funeral director: Louis Stein Inc.

Address: Cumberland.

19. Jan. 15 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 12th., 1940, about 1A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h____ alive on ____ 19__.

Immediate cause of death: Gunshot 32 caliber bullet, 8th., interspace, nipple line, left.

Due to:

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings:

Of operations: none

Of autopsy: none

DURATION

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 1-12-40

Where did injury occur? Cumberland, Allegany, Maryland (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): office

Means of injury: gunshot Injured at work? no

23. SIGNATURE: Pierce H. Corson, M.D. M. D. or other

Address: Cumberland, Maryland Date signed: 1/12/40

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

(T)

RECEIVED
FEB 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117a)

CERTIFICATE OF DEATH

0104

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days) 2 days
Stay in this community (yrs., or mos., or days) 3 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 414 Bell St
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR ~~217-10-1620~~

3. (a) FULL NAME William Henry Walliger

3. (b) Social Security Number 217-10-1620

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widower

6 (b) Name of husband or wife Audrey Frances Allen Walliger
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1906

8. AGE: Years 33 | Months 5 | Days 28 | If less than one day ____ hrs. ____ min.

9. Birthplace Renova, Pa (Town, county, and state)
10. Usual occupation Truck Driver
11. Industry or business Furniture Store

FATHER
12. Name Robert Walliger
13. Birthplace Lockhaven, Pa

MOTHER
14. Maiden name Gertrude Kepler
15. Birthplace West Port, Pa

16. Informant Mrs Claude Duckworth
Address Corriganville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 30, 1940 (month) (day) (year)
Cemetery or crematory Zion Memorial
Location Bedford Road Cumberland
16. Funeral director Jacob Hofer
Address Cumberland

19. Jan 30, 1940 (Date rec'd by registrar) J. T. Franklin, M.D. Registrar

Dr. M. C. Lowe

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1940, at 9P M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 26th 1940, to Jan 27th 1940, and that I last saw him alive on Jan. 27th 1940

Immediate cause of death	DURATION
Perforating Gastric Ulcer	1-26-40
Due to Peritonitis	
Due to	
Other conditions Hypostatic congestion	1-26-40

(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE James R. Nelson M. D. or other
Address 122 Bryant Date signed 1-27-40

RECEIVED
FEB 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

0105

Reg. Dist. No. 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Mt Savage
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days) —
Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegany
City or town Mt Savage Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Infant Walsh

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 23 - 1940

8. AGE: Years | Months | Days | If less than one day hrs. min.
Still Born

9. Birthplace Mt Savage Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name James R. Walsh
13. Birthplace Mt Savage Md

MOTHER
14. Maiden name Vera E. Stevens
15. Birthplace Mt Savage Md

16. Informant Mrs James R Walsh
Address Mt Savage Md

17. Burial
(Burial, cremation, or removal. Which?) Date thereof 1/27/40 (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director James R. Walsh (Father)
Address Mt Savage Md

19. 1/24 19 40 H. J. Bostetter MD
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 19 40, at 4.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
18, to 19,
and that I last saw alive on 19

Immediate cause of death	DURATION
Still Born	
Premature Birth	
Due to	
4 mos	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. J. Bostetter M.D.
M. D. or other
Address Mt Savage Md Date signed 1/24/40

RECEIVED
FEB 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0706

Reg. Dist. No. 1

1. PLACE OF DEATH:

County: Allegany

City or town: Little Orleans (Rural near)
(If outside city or town limits, write RURAL, NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Little Orleans (Rural near) Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: R. F. D. 1.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Ward

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 19. 1940

8. AGE: Years | Months | Days | If less than one day: hrs. min.

9. Birthplace: Little Orleans, Allegany Co. Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Herbert Ward
13. Birthplace: Fulton Co. Pa.

MOTHER
14. Maiden name: Pauline E. Yonker
15. Birthplace: Little Orleans, Allegany Co. Md.

16. Informant: Mrs. Edward Yonker
Address: Little Orleans, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 19. 1940 (month) (day) (year)

Cemetery or crematory: at home

Location: " "

18. Funeral director: Edward Yonker

Address: Little Orleans Md.

19. Jan 20 1940 (Date rec'd by registrar) T. T. Mann, Dep Mc Mann Dept Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 19 1940, at 6:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death	DURATION
Still born	
Due to The mother claimed to	
have had a fall three	
Due to days before the labor.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Dt operations:

Dt autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. A. Watson M.D.
M. D. or other

Address: Little Orleans Md Date signed: Jan. 19. 1940

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
FEB 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95)

CERTIFICATE OF DEATH

0107

Reg. Dist. No. 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Flintstone (Rural near)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or Inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 50

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Flintstone (Rural near) Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. —
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME: Mary M. Weddel

3. (b) Social Security Number: —

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	White	widowed

6 (b) Name of husband or wife: Calvin Weddel

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): July 22, 1868

8. AGE:

Years	Months	Days	If less than one day
71	6	7	—hrs. —min.

9. Birthplace: Allegany Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER
12. Name: August Bender
13. Birthplace: Germany

MOTHER
14. Maiden name: Elizabeth Peters
15. Birthplace: West Virginia

16. Informant: Joseph Weddel
Address: Flintstone Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 31, 1940 (month) (day) (year)

Cemetery or crematory: Robinettes Cemetery

Location: Pratt, Md.

18. Funeral director: Ephraim Smith
Address: Artemas Pa

19. Jan. 30 1940 (Date rec'd by registrar) D. Bennett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 29 1940, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 17 1939 to Jan. 29 1940, and that I last saw her alive on Jan. 29 1940.

Immediate cause of death	DURATION
Cardiac Dropsy	2 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: J. A. Watson M. D. or other

Address: Little Orleans Md. Date signed Jan. 29, 1940

RECEIVED
FEB 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

0108

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 475 Goethe St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 4 months.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Pa. County Venango

City or town Slippery Rock. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME Carrie Millicent Jones West.

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Widowed.

6 (b) Name of husband or wife Edward West.

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5, 1861

8. AGE: Years 78 Months 3 Days 14 If less than one day hrs. min.

9. Birthplace Clarion Co, Pa.
(Town, county, and state)

10. Usual occupation House work.

11. Industry or business At Home.

FATHER
12. Name James Jones
13. Birthplace Clarion County, Pa.

MOTHER
14. Maiden name Jane Coolsson
15. Birthplace Mifflin County, Pa.

16. Informant Harry Aaron

Address 328 Averett Ave. Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 24 1940 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md

18. Funeral director Jacob Hafer

Address Cumberland, Md.

19. Jan. 23 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19 1940, at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1940, to Jan 19 1940 and that I last saw her alive on Jan 19 1940

Immediate cause of death Chronic myocarditis — DURATION 2 yrs

Due to

Due to

Other conditions Arteriosclerosis — 18 mos

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. A. Trevaskis, M.D.
M. D. or other

Address Cumberland, Md Date signed 1/22/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

0109

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 173 N. Mechanic St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 61 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 173 N. Mechanic St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Simon A. Weston

3. (b) Social Security Number 235 No record AOD

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Emma Rose

6(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Sept 27 1878

8. AGE: Years 61 Months 3 Days 6 If less than one day ___ hrs. ___ min.

9. Birthplace Cumberland Allegany Md.
(Town, county, and state)

10. Usual occupation Printer (Retired)

11. Industry or business

FATHER
12. Name Simon Weston
13. Birthplace Huntington, W. Va.

MOTHER
14. Maiden name Anna Updegrave
15. Birthplace W. Va.

16. Informant George W. Weston
Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 5 40 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland

18. Funeral director Louis Stein Inc.

Address Cumberland

19. Jan. 5, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 3 1940, at 4:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 7 1939, to Jan 3 1940, and that I last saw him alive on Jan 1 1940 19

Immediate cause of death endocarditis & myocarditis

Due to Chronic endocarditis: several years. Chronic myocarditis: several years.

Due to C.O.G.R.

Other conditions Epilepsy.
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE T. Bailey Hunter MD
M. D. or other

Address Cumberland, Md. Date signed 1/4/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

0110

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital or institution: 212 Knox
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 2 Months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 212 Knox
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Hulda Electra Woodbury

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Webster Woodbury
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1845

8. AGE:

Years	Months	Days	If less than one day
94	11	22	____ hrs. ____ min.

9. Birthplace Lyndon Vt. (Town, county, and state)
10. Usual occupation Housekeeper
11. Industry or business At Home
FATHER 12. Name Isaac Dennison
13. Birthplace Lyndon, Vt
MOTHER 14. Maiden name Bemis
15. Birthplace Lyndon Vt.
16. Informant Kalbaugh
Address 212 Knox St Cumberland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 17 1940 (month) (day) (year)
Cemetery or crematory Norway Cem.
Location Norway Maine
18. Funeral director Jacob Hafer
Address Cumberland, Md
19. Jan. 15 1940 (Date rec'd by registrar) J. R. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/17/40 1912 15 at a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/10/40 19__, to 1/17/40 19__, and that I last saw h-- alive on 1/14/40 19__.

Immediate cause of death	DURATION
Myocardial Failure	
Due to Chronic Myocarditis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Richard L. Williams M.D.
M. D. or other
Address 37 Va. Ave Cumberland Md Date signed 1/16/40

JAN 29 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 452 Reg. Dist. No. 4

CERTIFICATE OF DEATH

0111

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 204 South Street.
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in this community (yrs., mos., or days) 6 wks

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Penna. (b) County Somerset Co.
(c) City or town Indiana R.F.D. 1 (If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Barbara Emma Zerfoss

3 (b) If veteran, name war —
3 (c) Social Security No. —

4. Sex: Female. 5. Color or race: White. 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or ~~wife~~: Robert M. Zerfoss.
6. (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) June 4, 1867

8. AGE: Years 72 | Months 7 | Days 11 | If less than one day ____hr. ____min.

9. Birthplace Penna. (Town, county, and state)
10. Usual occupation Housework.
11. Industry or business —

FATHER
12. Name Gabriel Spangler.
13. Birthplace Penna.

MOTHER
14. Maiden Name Mary Hockenberry
15. Birthplace Penna.

16 (a) Informant Rose Thompson
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 18, 1940 (month) (day) (year)
(c) Cemetery or crematory Garrett Cemetery
Location Garrett Pa.

18 (a) Funeral director Louis Stein, Inc
(b) Address Cumberland, Md.

19 (a) Jan 16, 1940 (Date rec'd by registrar) (b) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death January 15 1940, at 9:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 12 1940, to Jan 15 1940, and that I last saw him alive on Jan. 15 1940.

Immediate cause of death	Duration
Carcinoma of Pharynx	2 years.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death waa due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature J. P. Franklin M.D. M. D. or other
Address Cumberland Md. Date signed 1/15/40.

RECEIVED
FEB 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

0112

CERTIFICATE OF DEATH

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: PENNSYLVANIA County:
City or town: SPROUL Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: ✓

3. (a) FULL NAME: Dr. Lawrence Zinsmeister

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: JADWIZA SKORZEWSKA
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): JULY 29, 1880

8. AGE: Years	Months	Days	If less than one day
59	6	13	hrs. min.

9. Birthplace: PENNA. (Town, county, and state)
10. Usual occupation: Physician
11. Industry or business:
FATHER 12. Name: JOHN ZINSMEISTER
13. Birthplace: PENNA.
MOTHER 14. Maiden name: CATHERINE DIGLEY
15. Birthplace: PENNSYLVANIA
16. Informant: L.A. ZINSMEISTER
Address: SPROUL, PENNA.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-15-1940 (month) (day) (year)
Cemetery or crematory: Claysburg Pa.
Location: Claysburg Pa.
18. Funeral director: J.L. Bame.
Address: Claysburg Pa.
19. Jan 17 1940 (Date rec'd by registrar) Jos. S. Franklin, M.D. Registrar

MEDICAL CERTIFICATION 3:45 A.M.

20. DATE OF DEATH: JANUARY 12, 1940 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-22- 1939 to 1-12- 1940 and that I last saw h~~im~~ alive on 1-11- 1940

Immediate cause of death: (a) Chronic Myocarditis — DURATION
(b) Chronic Endocarditis
Due to: Congenital Auricular Fibrillation
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wm. F. Williams M. D. or other
Address: Cumberland Date signed 1-12-40

DR. W.F. WILLIAMS

RECEIVED
FEB 6 1940
BUREAU V. S.